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PRINCIPAL INVESTIGATOR: Beverly D. Taylor, M.D.

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Morehouse School of Medicine has developed a Breast Health Study that focuses on two groups: (1) minority, underserved women who are residents of Atlanta Housing Authority communities, and (2) primary care physicians and other health care providers who care for the medically underserved. The study seeks to determine and validate the efficacy of community-based educational program initiatives in promoting breast health in this population by educating and motivating target women to seek mammograms and often perform breast self-examinations on a regular basis. We also seek to determine and validate the efficacy of an innovative educational initiative in encouraging other health professionals to discuss and promote clinical breast exams, mammographies and breast self-examinations to their female patients.

During this first year of the study we have: redesinged the methodology; conducted two community-based focus groups and one focus group for health care providers; developed and pilot-tested the community assessment instrument; developed and pilot-tested the pre-test/post-test instruments for each population of the study; developed and pilot-tested the infodrama; identified leaders of each community and gained access to each community; and begun recruitment for the Community Lay Health Workers.

Pre- and post-test assessments will provide data relative to breast cancer knowledge, attitudes and practices among 200 low-income minority women who will receive an educational intervention and increased access for screening services. Two hundred women of similar circumstance and geographic composition will also be assessed but will receive no intervention until the end of the study.

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Beverly D. Taylor MD 7/30/95

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Hormones, both endogenous and exogenous, have been identified as a major etiological factor in the development of breast cancer. Although the highest incidence of breast cancer occurs in women aged 50 - 59, there is a first-peak occurrence in premenopausal women or menopausal women between the ages of 45 and 49. The high incidence in this age group is thought to be related to ovarian estrogens. The second peak incidence occurs in women between 65 and 69 years, and appears to be related to an imbalance of adrenal estrogens.[12, 13] Because of these findings, breast cancer is now thought of as two separate diseases based on menopausal status.[14] Breast cancer in premenopausal women is believed to be an aggressive disease, but it becomes less aggressive the more years that elapse between menopause and the onset of the disease.[15,16,17]

A strong correlation has also been established between lower socioeconomic status and shortened breast cancer survival.[18, 19, 20] Current statistics reveal that approximately 33% of all African Americans are poor. Freeman & Wasfie concluded that the rate of breast cancer survival was lower in their population of poor black women than in black women nationally, and that it was particularly low when compared to white women (whose socioeconomic status was unreported).[21]

In addition to higher mortality and lower survival rates, socioeconomically disadvantaged African American women face other unique problems. Allen and Britt noted that black women are disadvantaged members of the work force, and that on average, they take lower status jobs, earn less, and work longer than other major social groups.[22]

There is limited information published on effective interventions to increase breast cancer screening among black women. Black and white women alike are regularly exposed to health-related messages through the media and the work of public agencies and non-profit organizations. Commonly-used health education materials and approaches, however, may be inappropriate for minority populations. For example, the well-publicized breast cancers of Happy Rockefeller and Betty Ford may have stimulated many white women to seek breast exams and mammograms, but among blacks, these events may simply have strengthened the misunderstanding that breast cancer is a disease of well-to-do white women. Culturally appropriate interventions that use minority women models, employ culturally appropriate vocabulary, and are delivered by women of the same background are the ideal.[23]

The American Cancer Society estimates that there were 4,400 new cases and 1,100 deaths from breast cancer in Georgia in 1993, more than for any other type of cancer.[24] In Georgia, as in the nation, a racial disparity exists between black and white women in terms of 5-year breast cancer survival rates. Black women have a lower breast cancer incidence (70.3/100,000) than white women (92.9/100,000), but black women are more likely to have advanced breast lesions and are less likely to survive at all stages of this disease.[25]

Analysis of the randomized control trial being conducted by the Health Insurance Plan of Greater New York (HIP) suggests that periodic screening and early detection of breast cancer reduced the differential in 5-year survival rates between non-white and white women. Of those in the HIP control group, the non-white women had a lower 5-year survival rate (47%) than the white women (61%). However, the study group receiving periodic mammograms and clinical breast exams had no difference in 5 year survival rates between white and non-white women.[26] The National Health Interview Survey

found that black women had lower rates of mammography screening and breast examinations than white women. Black women over the age of 40 were twice as likely to have never heard of mammography. The rate of preventable breast cancer deaths for poor women was 2.5 times that of women of higher income.[27]

A study of Atlanta Surveillance, Epidemiology and End Results (SEER) Program of the National Cancer Institute showed that increased detection accounted for some but not all of the annual age-adjusted increase in invasive breast cancer of 29% among whites and 41% among blacks. Mammographic detection of asymptomatic lesions accounted for an incidence of 20-40% among whites and 13-25% among blacks. Other possible factors in early detection such as breast self-exam and awareness of breast health were not measured as these data were not recorded in medical records.[28]

A review of recent literature on promoting breast health makes it apparent that effective breast cancer prevention and early detection requires education of both health professionals and clients. The proposed project focuses on education of both consumers and health care providers.

The National Health Interview Study of trends in use of preventive health care by U.S. women found that the percent of women having a recent breast exam between 1973 and 1985 increased substantially for all women age 60 to 79. The increases were greater for black women (23%) than for white women (10%) in this age group.[29] The poor were less likely than others to have preventive cancer care in this study. Also discovered was that most women who did not have cancer screening procedures did have recent physician contact, "highlighting the need for greater emphasis on cancer prevention by health care providers."[30]

Based on the Mammography Attitudes and Usage Study (MAUS), mammography use by U.S. women increased since the 1987 National Health Interview Survey and this increase occurred during a period of more publicity about the need for mammograms. MAUS also found that use of mammography in 1990 was lower among black women than white women and lower among women with less income and education. In addition, 75% of women 40 years of age and older who had a mammogram reported that they did so because their doctor had recommended it. Forty-five percent of women who never had a mammogram said that their physicians had not suggested they get one.[31]

It has been found in a study of family physicians in New York State that most of the physicians believed that mammography was an effective procedure for detecting breast cancer in its early stages, but many of them did not advise their patients to seek screening.[32]

Women eligible for mammography report that the most important reasons for not receiving a recent mammogram are that they "did not need it" (had no symptoms or were not in a high-risk group), or that their "doctor did not recommend it." In surveys, physicians report a number of barriers to their recommendation of mammography to patients, including cost, belief that the examination is unnecessary, and concerns about the risk of radiation exposure. Cost has been reported by women as a barrier to mammography utilization. In addition, low education and income, advancing age, and the lack of a usual source of health care have been associated with lower mammography utilization rates.[33]

While utilization of mammography screening often begins with a physician recommendation, obtaining the screening ultimately depends on the behavior of the client. One study of older black women found that client health beliefs had little influence on acceptance and completion of mammography. Education, knowledge of cancer control and screening resources were more important barriers to carrying out physicians' advice. The authors state, "Women who know more about the detection procedures and recognized the increased risk of cancer with age were more likely to accept, other factors being equal."[34]

Previous Experience

The Atlanta Coalition on Breast Health was established in August 1990 by the Southeastern Region of the National Black Leadership Initiative on Cancer (NBLIC) to focus on the problem of breast cancer among black women in the Atlanta area. The coalition has implemented as its major project, the Black Women's Mammography Education and Screening Project, a community education model developed by the National Medical Association Council on Concerns of Women Physicians in cooperation with the Minority Health Education Program, Office of Cancer Communications, National Cancer Institute. A long-term goal of the NBLIC is to replicate the structure and activities of the Atlanta coalition in other parts of Georgia and the region.

The membership of the Atlanta Coalition on Breast Health includes a variety of health care professionals and other community leaders including representatives from Morehouse School of Medicine, black health care professional associations, ministerial groups, public and community health agencies and breast cancer survivors. These individuals participate in the coalition on a voluntary basis--evidence of their commitment to breast health among minority women.

Since its establishment in August 1990, the coalition has accomplished a number of important initiatives including:

- The coalition has researched and developed a facility guide of ACR-approved mammography screening sites in the Atlanta area.

- A curriculum was developed for a breast health education and training class for minority women. Designed to be culturally appropriate, the content includes materials of appropriate reading level, information on the incidence of breast cancer among black women, risk factors for breast cancer including diet, the importance of early detection, screening guidelines and teaching of breast self-exam techniques. It is based on a philosophy of empowering minority women to rely on themselves and community resources for early detection/prevention of breast cancer.

Over the past year Coalition members have been actively involved in the planning and development of the Breast Health Education Study. The primary function that Coalition members will satisfy for this project is that of a trained workshop facilitator. They will provide the educational workshops for women of the targeted communities as well as for the Community Lay health Workers.

The Morehouse School of Medicine Cancer Screening Project entitled, "Avoidable Mortality from Cancer in Black Populations (AMCBP) targeted black women in the inner-city. The study sought to determine if an in-home educational intervention conducted by a Lay Health Worker could increase adherence among low-income black women to breast cancer screening schedules as well as increase the women's knowledge and change their attitudes regarding these cancers. The results of the study showed a 2.9% increase in Pap smear screening, and a 34.5% increase in breast screening. AMCBP's study method of educational intervention differs from those in the proposed project (in-home vs. community group); however, the target group is the same, and the proposed study emphasizes cultural appropriateness and is based on a philosophy of empowering low-income black women to help themselves and one another.[12]

Purpose of the Present Work:

The purpose of this project is to impact favorably, the breast health of low income , underserved minority women. As stated previously, the project addresses three of the overall goals of *Healthy People 2000*:

. to increase the span of healthy life
. to reduce health disparities, and
. To acheive access to preventive services for all Americans

Two preventive services objectives:

. Objective 16.3 - to reduce breast cancer mortality, and
. Objective 16.11- to increase the proportion of women age 40 and older who have received a clinical breast examination and mammogram.

And, two Educational and Community-based Program objectives:

. Objective 8.1a - which seeks to increase the years of healthy life of black people, and
. Objective 8.11- which emphasizes increasing culturally appropriate community health promotion programs for minority populations.

We believe that a culturally appropriate, comprehensive breast cancer screening intervention in a low-income public housing project will increase rates at which women obtain clinical breast examinations and mammograms. If we are successful, these rates will approach the frequencies recommended by the National Cancer Institute.

Goals and Objectives:

The project Goal is as follows:

To test a comprehensive, culturally-appropriate breast cancer screening intervention in a low-income black community incorporating the Community Organization and Development Model. The intervention will aim to:

- to heighten breast cancer awareness in the entire community;
- to provide information on breast cancer screening to women in the community and motivate them to seek screening
- to provide information on breast cancer screening to health care providers in the community and motivate them to offer or prescribe screening routinely for their female patients, and

4. to increase access to breast cancer screening services.

This work proposes to achieve the following technical objectives:

OBJECTIVE 1: Organize each intervention cluster around the problem of breast cancer.

Sub-Objective 1.1 Define and describe the ecology of each cluster.

Sub-Objective 1.2 Organize a community breast cancer coalition in each cluster.

Sub-Objective 1.3 Identify, hire, and train one lay health worker for each cluster.

Sub-Objective 1.4 Conduct a community health needs assessment and baseline breast cancer knowledge, attitudes, and practices assessment in each cluster.

OBJECTIVE 2: Conduct programs to improve breast cancer knowledge, attitudes, and screening practices among members of the intervention communities at large, health care providers serving these community cluster, and women aged 35-79 residing in these communities.

Sub-Objective 2.1 Provide training workshops for 12 Atlanta Coalition Board members.

Sub-Objective 2.2 Provide an annual community-wide educational program in each target community.

Sub-Objective 2.3 Provide information and educational programs to 200 women aged 35-79 in the four community clusters.

Sub-Objective 2.4 Using the innovative infodrama approach, provide continuing education on breast cancer to physicians and other health care providers serving the intervention communities.

Sub-Objective 2.5 Increase access to breast cancer screening services for low-income women in the intervention communities.

OBJECTIVE 3: Evaluate the impact of the comprehensive intervention on breast cancer screening knowledge, attitudes, and practices.

Sub-Objective 3.1 Through pre- and post-intervention community health needs assessments, measure changes in knowledge and attitudes regarding breast cancer and its prevention in the intervention communities as compared to the comparison groups.

Sub-Objective 3.2 Through pre- and post-intervention questionnaires, measure changes in breast cancer knowledge, attitudes and practices (including obtaining breast exams and mammograms) among women aged 35-79 in the intervention communities as compared to the comparison communities.

Sub-objective 3.4 Through the use of pre- and post- questionnaires, determine the change among physicians and other health professionals serving the intervention communities in knowledge, attitudes, and beliefs relative to providing breast health care.

Methodology

It was necessary for us to change the methodology of the project over the past year from what was initially proposed, due to the lack of cooperation from the original communities once the project got underway. This resulted in significant changes in the methodology. The new methodology is as follows:

We will conduct a comparison analysis of the communities identified based on age and the fact that they live in public housing (an indicator of low income). The project will be carried out in two community clusters in the Metropolitan Atlanta Area. Working in conjunction with the Atlanta Housing Authority (AHA), we decided to use a cluster of communities in housing complexes that are described by AHA as "low rise" units (those units that house families ***with or without*** children where the head of household is less than 62 years of age); and another cluster of communities in complexes described as "high rise" units (those units housing families ***without*** children where the head of household is 62 years of age or older). Several communities were paired in each high rise cluster to provide adequate numbers of residents to be surveyed.

Each cluster will have two groups. The groups are:

Cluster I: (High Rise Cluster) consists of groups A and C.
Cluster II: (Low Rise Cluster) consists of groups B and D (see figure 1.0).

Cluster I: Groups A and C are the communities from which we will gather participants who fit the age criteria set by the National Cancer Institute's guidelines for mammography screening.

Cluster II: Groups B and D are the low rise communities from which we will gather participants with a variety of ages. We will provide these participants with a forum that teaches early education and prevention practices. All of these communities have been identified by AHA as well organized communities that would be receptive to community intervention.

The *case* and *comparison* groups (A,B,C,D,), will each complete a pre-test questionnaire conducted by the project interviewer. The high rise *case group* (Group A) will receive the educational intervention while the highrise *comparison group* (Group C) will receive none *(fig. 2.0)*. After the intervention, women $\geq$ 35 years of age in both groups will receive post-test #1. In order to expose all participants to breast cancer prevention education, the *comparison* groups will subsequently receive the educational intervention. Thus, after the first post-test is administered, the low rise *case* group (GroupB) and the high rise (former) *comparison* group (Group C) will receive the intervention.

Women in all four groups will receive post-test #2 after the intervention completed on groups B and C. The low rise comparison group (D) will then receive the intervention. We will then continue with the original study design where all women $\geq$ 35 years of age will be followed to determine whether the interventions had any effect on their breast cancer screening behavior.

The communities selected are listed in fig. 1. They include:

Cluster I:	Antone Graves	Cosby Spears I
	Graves Annex	Cosby Spears II
	Martin Luther King	John O. Childs

The number of units and the number of individuals who live in each community is listed beneath each name. Cluster I represents the high-rise cluster.

Cluster II: East Lake Meadows
Carver Homes
Cluster II represents the low-rise cluster which houses younger community members.

We have designated case and comparison groups for each cluster. The clusters are geographically distant from each other but remain within the metro Atlanta area. These communities have been

essentially untouched by previous efforts to organize and provide health intervention practices in a meaningful way. Groups A and B will provide our "cases"; Groups C and D will be the "comparison" groups.

We will use community lay health workers who will be recruited from the communities we have selected to include in the project. We will provide breast health education to the study participants in groups, through workshops, as opposed to providing individual instruction.

The Infodrama methodology will continue as described in the original document. A statement of our progress to date will be provided in the next section.

Body:

Progress to date:

We will review our progress based on the stated goals and objectives:

OBJECTIVE 1: Organize each intervention community around the problem of breast cancer.

Sub-Objective 1.1 Define and describe the ecology of each community.

New communities were identified and approached for inclusion in the study as described in the Methodology Section.

Sub-Objective 1.2 Identify, hire, and train one lay health worker for each community cluster.

Selection of Community Health Workers

Efforts began in April/May, 1995 to design a strategy to recruit Community Health Workers (CHW) for participation in both the Community Breast Health Assessment and the overall Breast Health Education Study. Telephone contact was made and appointments were scheduled with leaders from communities to be included in the BHES. BHES staff met with community leaders and provided them with an orientation overview of the BHES. These leaders were from the following communities:

- J. O. Chiles
- Cosby Spears I & II
- Carver Homes
- Antoine Graves/Graves Annex
- Martin Luther King
- East Lake Meadows

Community leaders were extremely receptive to the project. BHES staff requested that each community leader begin identifying and recommend several community residents they felt would serve as committed Community Health Workers.

Community leaders were instructed that the selection process would be a formal one, and each was given the following:

- a "flyer announcement" to be used in advertising for Community Health Workers
- an "application form" to be completed by interested residents (see attachments)

Community leaders, however, raised important concerns for the residents regarding how the Community Health Worker position would impact on the residents public subsistence. For example, most community residents in the study communities are ongoing recipients of food stamps, Medicaid, WIC, SSI, etc. BHES staff followed up this concern by contacting the Fulton County Department of Family and Children Services (DFCS) to ask their assistance in resolving this potential problem. An ongoing dialogue is presently taking place between BHES staff, DFCS staff and community leaders. DFCS staff is presently in the process of researching and reviewing all policies, and is making contact with its counterpart agencies at the State and Federal Government levels. DFCS is committed to assisting BHES staff to resolve this concern to the full satisfaction of both community leaders and potential community health workers.

Meanwhile, community leaders have begun to submit applications for the Community Health Worker (CLHW) positions, as BHES and DFCS staff continues to work out all details concerning methods of payment and training efforts for the workers.

Sub-Objective 1.3 Organize a community breast cancer coalition in each community.

CLHWs will establish a "community breast cancer coalition" consisting of community members ranging from the very poor who are the most important participants to community leaders such as politicians, educators, and business people. The intent will be to give the community the benefits of self-help, self-reliance and "ownership" of the Breast Health Education Study. While including representatives from lower socio-economic strata, the coalition will also include persons with influence and access to state and local resources in order to promote continuation and expansion of the program beyond the limits of federal funding.

Sub-Objective 1.4 Conduct a community health needs assessment and baseline breast cancer knowledge, attitudes, and practices assessment in each community.

Constructing the Questionnaire:

The purpose of the breast health education community assessment is to collect data and information concerning the knowledge, attitudes and practices of low-income community residents about their health. Breast health care will be the primary data returned from the assessment. The first draft of the Breast Health Community Assessment questionnaire was constructed by modifying an existing

community assessment instrument which had been originally developed and implemented by staff of the Health Promotion Resource Center at Morehouse School of Medicine. Next, in order to assure comparability with other studies, wide use was made of standard health questions which focus on chronic and infections diseases and their risk factors. Many of these questions were selected by reviewing standard health questionnaire instruments conducted nationally such as the U.S. National Health Interview Survey, the Behavioral Risk Factor Study Survey, the Mammography Attitudes and Usage Study and the Atlanta Surveillance and Epidemiology and End Results Program (SEER), etc. All questions were then reviewed and evaluated at length by BHES staff, and other MSM Faculty, to assure its cultural sensitivity and linguistic appropriateness for the study population.

Efforts were also made to place survey questions in proper sequence and format to create smoothness in flow, to reduce any possibility of respondent drop out, and to increase ease and accuracy in recording and coding responses by the interviewer. Also, an in depth statement concerning confidentiality was included at the beginning of the instrument for interviewee assurances.

Several other format modifications were made to the questionnaire instrument before a finished product was available for pre-testing. These format modifications were primarily focused at making the questionnaire response format compatible with the Epidemiology Information Data Base (Epi-Info).

Testing of the Health Assessment Instrument

Pre-test are indispensable, they help to reveal information that assist in making improvements to any community assessment instrument. A small scale pre-test was conducted during the month of March using the Breast Health Education Community Assessment. The purpose of the pre-test was to:

- Clarify all concepts and objectives surrounding the community assessment
- Identify any defects in the overall design of the assessment instrument
- Further modify the assessment instrument
- Familiarize BHES staff with a community environment similar to that of the study communities
- Measure the overall practicability, reliably and validity of the instrument.

The pre-test served as a "dress rehearsal" for the actual assessment, to begin in the Fall of 1995. With the assistance from staff of the Joyland/Highpoint Community Coalition Board, a community-based agency organized by Morehouse School of Medicine in 1989, interviewees were recruited to participate in the pilot-test of the Breast Health Education Survey Pilot.

Over 28 individuals from the community agreed to participate in the pre-test when asked by coalition leaders. Only ten individuals came to participate at the scheduled time. It is important to note that community residents participating in the pre-test, though chosen haphazardly, were not residents of the BHES population. These individuals, however, were asked to participate because of the similarity in their characteristics to those residents to be interviewed in the study community.

The BHES-Health Educator administered (Interviewer) the pre-test to all ten participants. During and after the interviews the interviewer recorded the following notations:

- Interviewee responses to each question
- Interviewee reactions (boredom, invitation, impatience, antagonism etc.)
- A critique and suggestions concerning specific questions
- Possible format changes for the instrument
- Time taken to complete the instrument

The Health Educator also conducted short follow-up discussions with several of the respondents after the administration of the survey, to determine if the respondent found the questions clear, what the respondent meant by his/her answers (interpretation), and/or why they "refused responses" or answered "don't know" to certain questions.

Questionnaire Revision/Modification

Based on the pre-test, the Community Health Assessment Questionnaire Instrument was modified. Closed-ended (or fixed-alternative) questions, with limited use of open-ended (or free response) was determined to be the preferred form of response for the assessment questionnaire. With this format, the respondent will be provided a specific range of alternative responses, but these will be responses the respondent can be expected to know. Modification to the questionnaire was made to assure cultural sensitivity, increased clarity and reduced ambiguity clarity for each question.

Cultural sensitivity and linguistical appropriateness never was of major concern to BHES staff. Efforts were made to assure that each question was phrased in language that the respondent would be certain to understand. Education levels in many low-income communities is low (5-6th grade reading level), thus, mis-interpretation can be constant. Double-barreled, uncommon medical terminologies and any offensive questions were readily deleted.

Epidemiology Information System (Epi-Info) was agreed upon by BHES staff, to be the data entry and analysis system to be used for the community assessment. Therefore, extensive time was spent by staff in modifying the questionnaire format (responses) to assure ease in data entry into the epi-info software. Coding, columns, fields etc. were all closely considered in questionnaire design and formatting. The Epi-Info systems is now in place and will continue to be modified as necessary during data entry during and after actual study assessment.

OBJECTIVE 2: Conduct programs to improve breast cancer knowledge, attitudes, and screening practices among members of the intervention communities at large, health care providers serving these communities, and women aged 35-79 residing in these communities.

Sub-Objective 2.1 Provide training workshops for 12 Atlanta Coalition members.

The BHES-Health Educator administered (Interviewer) the pre-test to all ten participants. During and after the interviews the interviewer recorded the following notations:

- Interviewee responses to each question
- Interviewee reactions (boredom, invitation, impatience, antagonism etc.)
- A critique and suggestions concerning specific questions
- Possible format changes for the instrument
- Time taken to complete the instrument

The Health Educator also conducted short follow-up discussions with several of the respondents after the administration of the survey, to determine if the respondent found the questions clear, what the respondent meant by his/her answers (interpretation), and/or why they "refused responses" or answered "don't know" to certain questions.

Questionnaire Revision/Modification

Based on the pre-test, the Community Health Assessment Questionnaire Instrument was modified. Closed-ended (or fixed-alternative) questions, with limited use of open-ended (or free response) was determined to be the preferred form of response for the assessment questionnaire. With this format, the respondent will be provided a specific range of alternative responses, but these will be responses the respondent can be expected to know. Modification to the questionnaire was made to assure cultural sensitivity, increased clarity and reduced ambiguity clarity for each question.

Cultural sensitivity and linguistical appropriateness never was of major concern to BHES staff. Efforts were made to assure that each question was phrased in language that the respondent would be certain to understand. Education levels in many low-income communities is low (5-6th grade reading level), thus, mis-interpretation can be constant. Double-barreled, uncommon medical terminologies and any offensive questions were readily deleted.

Epidemiology Information System (Epi-Info) was agreed upon by BHES staff, to be the data entry and analysis system to be used for the community assessment. Therefore, extensive time was spent by staff in modifying the questionnaire format (responses) to assure ease in data entry into the epi-info software. Coding, columns, fields etc. were all closely considered in questionnaire design and formatting. The Epi-Info systems is now in place and will continue to be modified as necessary during data entry during and after actual study assessment.

OBJECTIVE 2: Conduct programs to improve breast cancer knowledge, attitudes, and screening practices among members of the intervention communities at large, health care providers serving these communities, and women aged 35-79 residing in these communities.

Sub-Objective 2.1 Provide training workshops for 12 Atlanta Coalition members.

Now that the communities have been identified and it looks as though we will be able to recruit CHWs from within the community, we are ready to begin training the Coalition members.
Members of the Atlanta Coalition will serve as workshop leaders and instructors for the community-based educational programs targeting low-income and minority women. We propose one *Train the Trainer* workshop scheduled for August 11, 1995, and at least one in subsequent years on an as-needed basis as new members join the Coalition and wish to become involved in the proposed educational initiatives. Additionally, mini seminars will be offered beginning in Year 02 to provide our trainers with the most up-to-date information regarding breast health.

Curriculum for the *Train the Trainer* workshops includes the following modules:

Content	Method	Instructor
Communication, teaching, and motivational techniques for the following modules:	Lecture/Discussion	Morris
1. Breast cancer stats, risk factors for low-income and minority women	Slides Printed materials	Taylor
2. Importance of early detection/screening guidelines & resources	*Printed materials* *Discussion*	*Taylor*
3. Diet, nutrition, and stress, and social implications of cancer	Printed materials Discussion	Glenn
4. Breast Self Examination	Breast Models Return Demonstration Shower Cards/ Special Touch video/ Shower Cards	Sheats/Davis
5. Q & A	Discussion	Panel

Sub-Objective 2.2 Provide an annual community-wide educational program in each target community.

We will assist the coalition in organizing an annual health promotion/education event within the target intervention communities. An example of such an event might be a health fair that may be based on

the intervention communities but include participation from neighboring communities as well. The first such event would focus on breast health and include a presentation of the community health needs assessment data and breast cancer questionnaire results. Subsequent events would focus on other health concerns on the communities; funding would be provided through community-based fundraising efforts. MSM would provide technical assistance on an as-needed basis. Having embarked upon a program of community empowerment based initially on breast health promotion, we believe that continuation of this effort is an important element of the empowered community.

Sub-Objective 2.3 Provide information and educational programs to 200 women aged 35-79 in the four cluster communities.

We propose to conduct a controlled study in each of the target areas. We will recruit an intervention cohort of 100 women from each of the four cluster communities to participate in the breast health education workshops. One hundred (100) will be solicited in Year 02, 100 in Year 03. The same number of women who do not participate in the educational programs (comparison groups) will be recruited throughout the study. Year 03 will be also be used for follow-up, and at the end of the study, we will make the educational programs available for the control group.

Sub-Objective 2.4 Using the innovative infodrama approach, provide continuing education on breast cancer to physicians and other health care providers serving the intervention communities.

Physician's Breast Health Care Survey

The Physician Breast Health Care Survey was designed to measure knowledge, attitudes and practices of physicians concerning breast health care. The survey was designed to measure physician perceptions concerning prevention counseling, amount of time devoted to preventive counseling, availability and use of culturally appropriate literature and brochures, referral practices for breast cancer screening, cancer screening test and procedures used and perceived barriers to women's health promotion. The survey is a 25 - question self-administered questionnaire. (see attachment)

In May of 1995, a pre-test of the survey was conducted at Grady Memorial Hospital for faculty and residents of the Department of Medicine. The pre-test was conducted prior to the pilot-testing of the BHES Info-Drama. Modifications were then made to the instrument both in format and in questions. In June 1995, the questionnaire was conducted as a "pretest," prior to the BHES Info-Drama, with physicians attending the 1995 Annual Conference of the Georgia State Medical Association (GSMA) held at Hilton Head, South Carolina. Physicians made suggestions concerning the need to modify the instrument format for "quicker response time." However, they felt the content of the questions to be relevant and appropriate for gathering information from practicing physicians related to breast health care. Additional modifications are currently being made to the instrument by the BHES Health Education Consultant.

Sub-Objective 2.5 Increase access to breast cancer screening services for low-income women in the intervention communities.

Study participants will learn about screening guidelines and the importance of early detection of breast cancer. **While the proposed study will not provide actual screening services**, we will provide participants with specific information regarding where mammograms are available at low or no-cost. This will be accomplished, in part, by identifying at least 5 ACR-approved sites, including mobile units, for low and no cost mammograms for women who attend a project workshop. We hypothesize that this specific information coupled with the educational workshop experience will constitute a persuasive influence in motivating participants to seek preventive care.

Women will be instructed on how to determine if their third party coverage includes mammogram screening. For example, the state of Georgia requires health insurers to cover the cost of screening mammograms, but this is a relatively new requirement, and understanding and compliance is not uniform. Further, full or partial payment might be available to some who are Medicare eligible. The 1988 Medicare Catastrophic Coverage Act provides a maximum of $50 for screening mammograms for Medicare beneficiaries as of 1990.[13]

At least 3 resources will be identified and made available to supplement the cost of mammogram screening for workshop participants who meet indigent criteria or are unable to bear the total cost of the procedure(s). Providers of mammography will be approached about accepting discount coupons from workshop participants. Applications to corporations and foundations will be made to fund mammograms for those women attending the workshops who have no other way of paying for these services. For example, in all of the target sites of the proposed project, there are health care facilities that meet the state criteria as Disproportionate Share Hospitals (DSH). This entitles these medical centers for an entitlement under the state's Indigent Care Trust Fund, a program administered by the State of Georgia Department of Medical Assistance. The Department has used almost $238.9 million of Trust Fund monies to provide payment adjustment for disproportionate share hospitals to cover the significant cost of providing services to Medicaid and other low-income patients. Hospitals must use 15% of their payment adjustment for primary care services as described in plans approved by the Department and each hospital's respective district health director. Almost $36 million of the rate adjustment will be used for such services.

OBJECTIVE 3: Evaluate the impact of the comprehensive intervention on breast cancer screening knowledge, attitudes, and practices.

Sub-Objective 3.1 Through pre- and post-intervention community health needs assessments, measure changes in knowledge and attitudes regarding breast cancer and its prevention in the intervention communities as compared to the comparison community.

Sub-Objective 3.2 Through pre- and post-intervention questionnaires, measure changes in breast cancer knowledge, attitudes and practices (including obtaining breast exams and mammograms) among women aged 35-79 in the intervention communities as compared to the control community.

Clearly, this portion of our annual report is the most incomplete. We have pilot tested the Infodrama, developed and field tested the necessary questionnaires, identified our communities and have planned the training session for the Coalition members. The next year of the project (PGY2) offers us the opportunity to obtain data to support our hypothesis. We offer the following as a review of our intentions.

Target community participants will be asked to provide complete mailing and telephone information at registration. Before the beginning of the program, participants will be asked to complete a self-administered questionnaire to obtain baseline information relative to breast health. Items assessing the following aspects will be included: level of cancer awareness including prevalence of disease, management, and curability of stage-specific disease, breast cancer screening history, and sociodemographic data (age, race, occupation, educational level, and family income). The questionnaire will contain questions focusing on breast health knowledge, awareness of breast cancer warning signals, and attitudes toward breast cancer.

Following participation in the proposed intervention, participants will be asked to complete a similar (but not identical) questionnaire to assess the educational effect of the program. These data will then be analyzed in order to determine the relative efficacy of the various modules of the program.

The pre-workshop assessment questionnaire that we plan to utilize was modified from the 24-item Breast Cancer Awareness Survey developed by the National Black Leadership Initiative on Cancer. The modifications were completed by our health educator, Mr. Fred Murphy. The pre-workshop assessment instrument was used during the pilot testing with a community focus group .

Sub-objective 3.4 Through the use of pre- and post- questionnaires, determine the change among physicians and other health professionals serving the intervention communities in knowledge, attitudes, and beliefs relative to providing breast health care.

One purpose of the Breast Health Education Study is to implement and evaluate an intervention that will motivate primary care physicians to:

1) discuss breast health care issues with their patients and

2) to recommend regular breast self-examinations, clinical breast examinations, and screening mammograms to them.

The intervention which was developed for this purpose is in the form of an Infodrama, a 45 minute dramatic presentation followed by a 30 minute discussion with the audience.

The Infrodrama was developed through a contractural agreement with Charlie Lambert, Founder and President of Educational Playmakers. Much of the body of the skit was derived from focus group sessions we conducted with physicians as well as women of all ages, who are similar to the population we serve. The Infodrama is presented by 4 professional actors. The audience discussion that follows is moderated by a physician .

For the purpose of the Breast Health Education Study, the Infodrama focuses on the dynamics of physician-patient communication as it relates to breast cancer prevention and control, the barriers that inhibit physicians from providing adequate breast health education to their patients, and the barriers that prevent women from complying with breast cancer screening recommendations. The script for the presentation was developed by the Breast Health Education Team using current research studies on the social and cultural issues surrounding breast cancer screening.

Using a pretest-posttest control design, the intervention is evaluated by measuring changes in physician's knowledge, attitudes, and practices regarding breast health care. A self-administered questionnaire is given immediately prior to the Infodrama and is mailed to study participants 6 months afterwards. A control group receives the pre- and posttest questionnaires, but not the intervention. The outcome indicators that are measured include:

- knowledge of breast cancer risks and breast cancer screening recommendations
- the perceived importance of breast cancer prevention and control counselling
- the amount of time devoted to breast cancer prevention and control counselling
- referral habits for breast cancer screening
- breast cancer screening tests and procedures usually recommended
- knowledge of barriers that prevent women from adhering to breast cancer screening recommendations

Conclusions

Morehouse School of Medicine has initiated the Breast Health Education Study funded through a grant awarded by the Department of Defense. The study proposes to focus on two population groups: 1) minority and underserved women residing in low income housing and, 2) primary care providers of these and other women. The study will use community based workshops that are designed to be culturally sensitive for the population of women. An info drama has been designed to educate the caregiver.

Progress to date has mostly been steady. We did have a major problem with the study design when one of the original communities declined to continue with us. This caused a six month delay while we designed a new methodology.

The current methodology calls for a community cluster comparison between cases and comparison groups who reside in high rise complexes and case and comparison groups who reside in low rise complexes. This allows a broader demographic base from which to gather data.

We have been successful in designing and pilot testing the community assessment survey instrument, the pre-test and post-test instruments for the community based workshops, and for the Infodrama workshops designed for health care providers. We have also designed and pilot tested the Infodrama.

We have not completed the statistical analysis of the Infodrama pilot test at this time. Our preliminary data shows that the instruments we've designed are viable and will yield us the kind of information that we are seeking.

We anticipate a very busy and fruitful year two with the hiring and training of the Community Lay Health Workers this September. They will assist us in educating their communities and in gathering the results of the community assessments.

Bibliography

1. Healthy People 2000. National Health Promotion and Disease Prevention Objectives. DHHS Publication (PHS) 91-50212. U. S. Government Printing Office, Washington DC 20402, 1990

2. Freeman, HP. Cancer in the socioeconomically disadvantaged. CA 39:266-288, September/October, 1989.

3. Seidman, H., Mushinski, MH, Gelb, SK, & Silverberg, E. Probabilities of eventually developing or dying of cancer -- United States. CA 35:36-56, January/February, 1985.

4. Greenberg, RS, Sung, JFC, Liff, JM, & Clark, WS. Incidence and survival rates for cancer in Atlanta, 1975-1985. J Med Assoc Georgia 77:712-719, 1988.

5. Greenberg RS, Liff, JM, Clark, WS, and Sung, JFC. Report of the Georgia State Cancer Registry, 1975-1985. J Med Assoc Georgia 77:895-900, 1988.

6. Freeman, 1989.

7. Baquet, C, Ringer, K, Young, J (1986). Cancer among Blacks and other minorities statistical profiles. National Cancer Institute, NIH publication #86-2785.

8. Breiele, H, Walker, M. Wild, L & Wood, F (1986). Results of treatment of stage I-III breast cancer in Black Americans: The

9. Farley, T & Flannery, JT (1989). Late-stage diagnosis of breast cancer in women of lower socioeconomic status: Public health implications. American Journal of Public Health, 79 (11) 1508-1512.

10. Hardy, RE & Newell, GR (1988). Cancer and the Minority community: Epidemiological Studies. The Cancer Bulletin 40 (2), 71-74.

11. Breiele, H. et al., 1990.

12. Cox, E. B. (1987). Breast Cancer in the elderly. Clinics in Geriatric Medicine,3 (4), 695-713.

13. Farley, T. & Flannery, J.T. (1989). Late-stage diagnosis of breast cancer in women of lower socioeconomic status: Public health implications. American Journal of Public Health,79(11), 1508-1512.

14. Freeman, H. & Wasfie, T.(1989). Cancer of the breast in poor Black women. Cancer,63(112), 2562-2569.

15. Staraky, K. M., Kincade, J.E., Stewart, M. A. & Donner, A.P. (1987). The effects of socioeconomic factors on the early prognosis of cancer. Journal of Chronic Disease,40(3), 237-244.

16. Freeman & Wasfie, 1989.

17. Allen, L., & Britt, D.W. (1983). Black women in American society: A resource development perspective. Issues in Mental Health Nursing, 5(4), 61-79.

18. Blumenthal, DS, Avery, B., Sung, JFC, Greenberg, RS, Liff, JM & Coates, RJ. Avoidable Mortality from Cancer in Black Populations--Cancer Screening Intervention in Black Women in an Inner-City Community. Final Report of NCI N01-CN-65032. Morehouse School of Medicine, Atlanta, GA, 1992.

19. Cancer Facts & Figures 1991, American Cancer Society, Atlanta, GA

20. Greenberg, R. et al. Report of the Georgia State Cancer Registry 1975-1985, MAG 77:895-900, 1988.

21. Shapiro, S, et al. Prospects for eliminating racial differences in breast cancer survival rates. AJPH 72:1142-1145, 1982.

22. Farley, T and Flannery, J. Late stage diagnosis of breast cancer in women of lower socioeconomic status: public health implications. AJPH 79:1508-1512, 1989.

23. Liff, J, Sung, J, et al. Does increased detection account for the rising incidence of breast cancer? AJPH 81: 462-465, 1991.

24. Mukuc, D., et al. National trends in the use of prventive health care by women. AJPH 79:21-26, 1989.

25. Ibid.

26. Centers for Disease Control. Use of mammography - United States, 1990. MMWR 39:621-630, 1990.

27. Cumming, KM, et al. Family physician's beliefs about breast cancer screening mammography. J Fam Practice 17:1029-34, 1983.

28. U. S. Department of Health and Human Services. The National Strategic Plan for the Early Detection and Control of Breast and Cervical Cancers. U.S. Government Printing Office, Atlanta, GA. June 1993.

29. Burack, RC and Liang, J. The acceptance and completion of mammography by older black women. AJPH 79:721-726, 1989.

30. Sung, J, et al. Morehouse's Avoidable Cancer Mortality Project: Cancer Screening Intervention in black women in inner-city community by lay health workers - study design and subjects.

31. Braithwaite, RL, Murphy, F, Lythcott, N & Blumenthal, DS. Community Organization and Development for Health Promotion Within an Urban Black Commuinity: A Conceptual Model. Health Education 20 5:56-60, 1989.

32. Blumenthal, D, Sung, FC, Williams, J, Coates, R, and Liff, J: Recruitment and Retention of Subjects in a Community-Based Cancer Prevention Project. Health Services Research, 1993, in press.

33. Thompson, G, et al. Breast cancer screening legislation in the United States: A commentary. AJPH 79:1541-1543, 1989.

APPENDIX

Personnel

The following is a list of all personnel currently working with the Breast Health Education Study:

Beverly D. Taylor, M.D.	Principal Investigator
Joyce Sheats, MPH,	Co-Principal Investigator
John F.C. Sung, Ph.D., MPH	Epidemiologist
Fred Murphy, MPH	Health Educator/Consultant
Bridgette Toodle	Administrative Secretary
Mable Densler, R.N.	Interviewer/ Community Lay health Worker Supervisor
TBN	Community Lay Health Workers (4)
Charlee Lambert	Consultant/Educational Playmakers

- No graduate degrees have been earned through the resources of this grant.
- Sherry Crump, M.D., M.P.H., is a Drew/Meharry/Morehouse Consortium Cancer Center Fellow who received funding through a DOD grant award to Meharry Medical College. She is an active participant in this study.

Meeting Abstracts

1. Taylor, BD, Sheats, J, et. al., " The Atlanta Coalition Breast Health Education Project". *Presented at the Fifth Annual Meeting of the National Black Leadership Initiative on Cancer - Southeastern Regional Meeting,* Atlanta, *GA. March 17, 1995*

2. Taylor, BD., Crump, S., Sheats, J., et. al., " An Education Model to Designed to Encourage Underserved Minority Women to Seek Mammograms". *Presented at the Drew-Meharry-Morehouse Consortium Cancer Center Symposium, March Meharry Medical College, Nashville, TN. Thursday March 23, 1995.*

3. Taylor, B.D., et al, and Educational Playmakers, "Nightmare", presented at the Annual meeting of the Georgia Medical Association. June19, 1995, Hilton Head, SC *An informational dramatic presentation for physicians attending the Georgia Medical Association's Annual Meeting at Hilton Head, SC. The Georgia Medical Association consists primarily of minority physicians of all ages and specialty areas who practice in the State of Georgia.*

4. Taylor, BD., Crump, S., Sheats, J., Lambert, C. et. al, "Nightmare", presented at noon conference Internal Medicine Residency Program, Grady Memorial Hospital

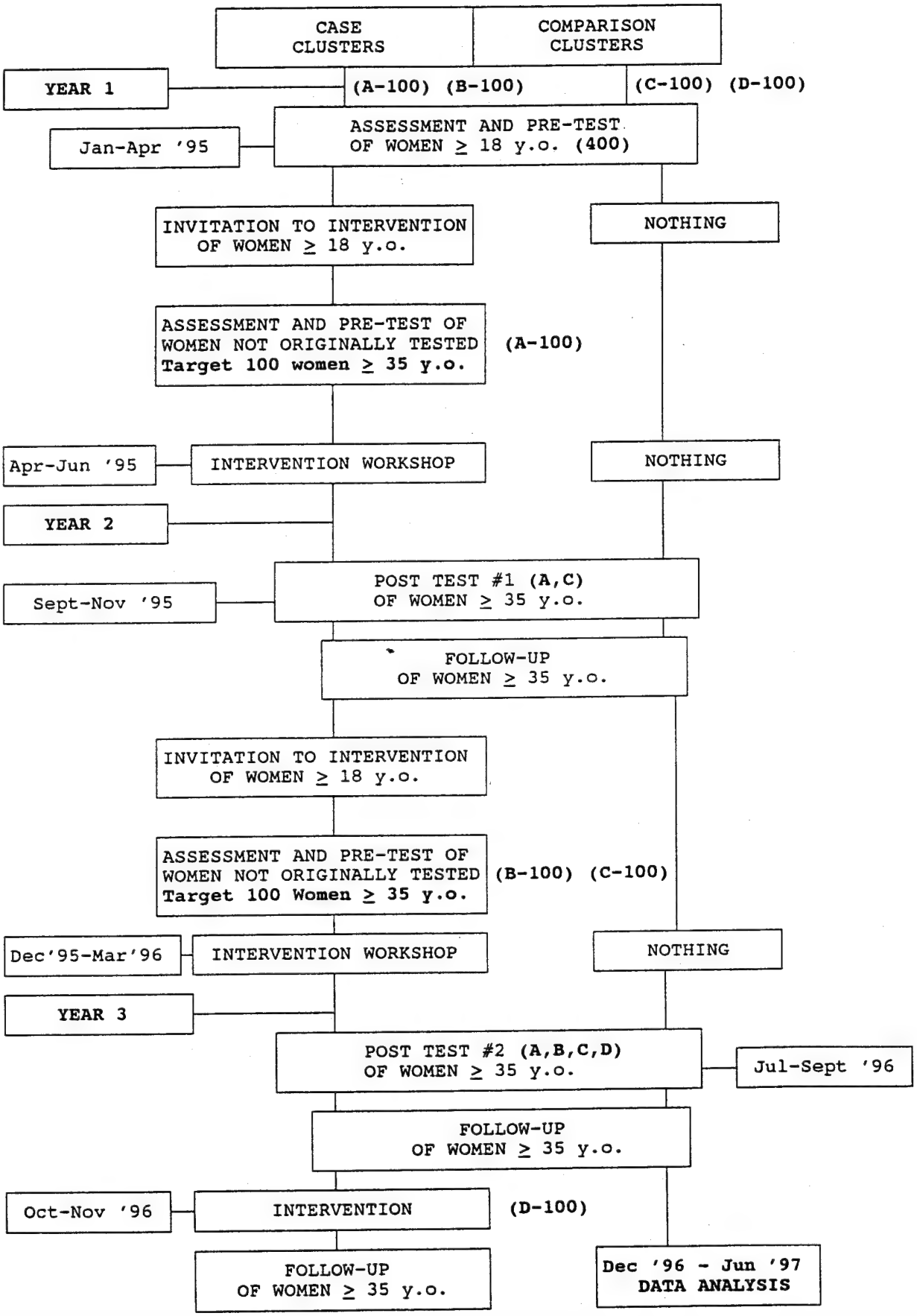
FIG. 1

BREAST HEALTH EDUCATION STUDY

CLUSTER I HIGH RISE UNITS Women ≥ 62 y.o.	CLUSTER II LOW RISE UNITS Women < 62 y.o
GROUP A (CASES) **Antone Graves** 210 Units 210 Individuals **Graves Annex** 100 Units 101 Individuals **Martin Luther King** 154 Units 142 Individuals	GROUP B (CASES) **East Lake Meadows** 650 Units 2,157 Individuals
GROUP C (COMPARISON) **Cosby Spears I/Cosby Spears II** 282 Units 291 Individuals **John O. Childs** 250 Units 255 Individuals	GROUP D (COMPARISON) **Carver Homes** 990 Units 2,612 Individuals

FIG. 2

BREAST HEALTH EDUCATION STUDY



BREAST HEALTH COMMUNITY ASSESSMENT

BEFORE BEGINNING THE INTERVIEW

HELLO: I AM_____

INTRODUCTION: READ TO RESPONDENT

This interview is designed to access the knowledge and attitudes of community residents about certain health problems. I will ask you questions about your thoughts and views regarding several health concerns like substance abuse, tobacco use, weight control, cancer, diet and nutrition. Of course, this interview is completely voluntary. If we should come to any questions you do not want to answer, please tell me and we will go on the next question. As indicated earlier, all of your answers will be held in the strictest of confidence.

RE-EMPHASIZE THE CONFIDENTIAL NATURE OF THE INTERVIEW, THEN STATE:

We are required to obtain your informed consent before beginning the interview.

HAND RESPONDENT THE CONSENT FORM.

READ THE CONSENT FORM AND REQUEST SIGNATURE IN APPROPRIATE PLACE.

INTERVIEWEE'S NAME: _____

INTERVIEWEE'S ADDRESS: _____

_____

(CITY) (STATE) (ZIP)

Do you have a telephone?

a. yes 1
b. no 2

INTERVIEWEE'S TELEPHONE NUMBER:_____

Can you give me the names, telephone numbers and addresses of 2 people who will know your whereabouts at all times?

Contact Person #1: Name: _____
Address: _____
_____
Phone #: _____

Contact Person #2: Name: _____
Address: _____
_____
Phone #: _____

INTERVIEWER'S NAME: _____

TODAY'S DATE: _____
M/D/Y

INTERVIEWER'S CODE: _____

TIME INTERVIEW BEGAN: _____ A.M. _____ P.M.

DEMOGRAPHICS

I would first like to ask you some general questions about yourself.

1. Gender of respondent

   a. Male 1
   b. Female 2

2. Date of Birth _____
   Month/Day/Year

3. Race of respondent

   a. White (non-hispanic) 1
   b. Black 2
   c. Hispanic (non-white) 3
   d. Hispanic (white) 4
   e. Other (**Specify**)_____

4. What is your marital status?

   a. Never married 1
   b. Married 2
   c. Living together as married 3
   d. Separated 4
   e. Divorced 5
   f. Widowed 6
   g. Refused response 9
   h. Other (**Specify**)_____

5. How long have you lived in this community? _____
   (years/months)

6. How long do you plan to live in this community? _____
   (years/months)

7. Are you the head of the household?

   a. Yes 1
   b. No 2
   c. Refused response 9

8. Beside you, how many other people live in this house? _____

9. What is the highest level of school (or schooling) that you've completed?

a. Did not complete high school (**highest grade completed**)_____ 1
b. High school graduate or GED 2
c. Some college or (technical, vocational training) 3
d. College graduate 4
e. Refused response 9
f. Other (**Specify**)_____

10. Which of the following describes your work history? **(PLEASE READ EACH RESPONSE)**

a. Currently employed (full-time) 1
b. Currently employed (part-time) 2
c. Currently unemployed **(SKIP TO Q-13)** 3
c. Self-employed 4
d. Homemaker 5
e. Retired **(SKIP TO Q-12)** 6
f. Student **(SKIP TO Q-14)** 7
g. Never employed **(SKIP TO Q-14)** 10
i. Refused response **[SKIP TO Q-14]** 9
h. Other (**Specify**)_____

11. How long have you been working at your current job?

a. Less than one year 1
b. One year or more 2
c. Three years or more 3
e. Refused response 9
d. Other (**Specify**)_____

12. If retired, how long did you work with your last employer? **(IF NOT RETIRED, GOTO Q-13)**

a. Less than six months 1
b. 6 months to 11 months 2
c. 1 to 2 years 3
d. 2 to 5 years 4
e. 6 to 10 years 5
f. 11 to 20 years 6
g. More than 20 years 7
h. Refused response 9

13. What is/was your occupation/job?

a. Secretary 1
b. Housekeeping 2
c. Construction Worker 3
d. Janitorial 4
e. Salesperson 5
f. Refused response 9
g. Other (**Specify**)_____

14. To what religious group do you belong?

a. Baptist 1
b. Methodist 2
c. Catholic 3
d. Episcopal 4
e. Muslim 5
f. Don't know/Not sure 8
g. Refused response 9
h. Other (**Specify**)_____

15. What would you say is the most important thing in your life right now?

a. God/Religion 1
b. Children 2
c. Spouse 3
d. Parent(s) 4
e. Friend(s) 5
f. Money 6
g. Health 7
h. Self 10
i. Job 11
j. Don't know/Not sure 8
k. Refused response 9
l. Other (**Specify**)_____

This next question is about your income, and is going to be used for the sole purpose of this study. As a reminder, the information you give me is confidential.

16. What was the total income of all persons living in your household in the last year (1994), that is, considering all sources: salaries, wages, unemployment compensation, profits, and interest?

a. Less than $5,000 1
b. $5,000 - $10,000 2
c. $10,001 - $15,000 3
d. $15,001 - $25,000 4
e. $25,001 - $40,000 5
f. More than $40,000 6
g. Don't know/Not sure 8
h. Refused response 9

MEDICAL AND FAMILY HISTORY

The next group of questions ask you to report your health history and family history. Please be as accurate as possible.

17. Compared to others your age, would you say that your physical health is:

a. Excellent 1
b. Good 2
c. Fair 3
d. Poor 4
e. Don't know/Not sure 5
f. Refused response 9

18. Has a doctor or other health care provider ever told you that you had any of the following: **(PLEASE READ EACH RESPONSE)**

a. High Blood Pressure . . . . . [1] Y [2] N [8] DK [9] Refused
b. Heart disease . . . . . [1] Y [2] N [8] DK [9] Refused
c. Breast Cancer . . . . . [1] Y [2] N [8] DK [9] Refused
d. Cervical Cancer (female) . . . . . [1] Y [2] N [8] DK [9] Refused
e. Prostate Cancer (male) . . . . . [1] Y [2] N [8] DK [9] Refused
f. Diabetes (sugar) . . . . . [1] Y [2] N [8] DK [9] Refused
g. High Cholesterol . . . . . [1] Y [2] N [8] DK [9] Refused
h. Cirrhosis of the liver . . . . . [1] Y [2] N [8] DK [9] Refused
i. AIDS . . . . . [1] Y [2] N [8] DK [9] Refused
j. T.B. . . . . [1] Y [2] N [8] DK [9] Refused

Has a doctor or other health care provider ever told you that you had any of the following: **(PLEASE READ EACH RESPONSE)**

k. Bronchitis (wheezing cough) . . . . . [1] Y [2] N [8] DK [9] Refused
l. Emphysema (lung disease) . . . . . [1] Y [2] N [8] DK [9] Refused
m. Arthritis . . . . . [1] Y [2] N [8] DK [9] Refused
n. Other (**Specify**)_____

19. Do you have any relatives who has ever had: **(PLEASE READ EACH RESPONSE)**

a. High Blood Pressure . . . . . [1] Y [2] N [8] DK [9] Refused
b. Heart disease . . . . . [1] Y [2] N [8] DK [9] Refused
c. Breast Cancer . . . . . [1] Y [2] N [8] DK [9] Refused
d. Cervical Cancer (FEMALE) . . . . . [1] Y [2] N [8] DK [9] Refused
e. Prostate Cancer (MALE) . . . . . [1] Y [2] N [8] DK [9] Refused
f. Diabetes (sugar) . . . . . [1] Y [2] N [8] DK [9] Refused
g. High Cholesterol . . . . . [1] Y [2] N [8] DK [9] Refused
h. Cirrhosis of the liver . . . . . [1] Y [2] N [8] DK [9] Refused
i. AIDS . . . . . [1] Y [2] N [8] DK [9] Refused
j. T.B. . . . . [1] Y [2] N [8] DK [9] Refused
k. Bronchitis (wheezing cough) . . . . . [1] Y [2] N [8] DK [9] Refused
l. Emphysema (lung disease) . . . . . [1] Y [2] N [8] DK [9] Refused
m. Arthritis . . . . . [1] Y [2] N [8] DK [9] Refused
n. Refused response . . . . . [1] Y [2] N [8] DK [9] Refused
o. Other (**Specify**)_____

20. If a relative has had breast cancer, what is the relationship? **(IF "NO" SKIP TO Q-21)**. **(PLEASE READ EACH RESPONSE)**

a. Mother . . . . . [1] Y [2] N [8] DK [9] Refused
b. Sister(s) . . . . . [1] Y [2] N [8] DK [9] Refused
c. Daughter(s) . . . . . [1] Y [2] N [8] DK [9] Refused
d. Other (**Specify**)_____

QUESTIONS 21 THROUGH 27 FOR FEMALES ONLY)

21. How many children have you had?

a.	0 **(SKIP TO Q-25)**	1
b.	1	2
c.	2	3
d.	3	4
f.	4 or more	5
e.	Refused response	9

22. How old were you when you had your first child?

a.	less than 15 years	1
b.	15-19 years	2
c.	20-24 years	3
d.	25-29 years	4
e.	30-34 years	5
f.	35 years and over	6
g.	Refused response	9

23. Was it a full term delivery?

a.	Yes	1
b.	No	2
c.	Don't know/Not sure	8
d.	Refused response	9

24. Did you breast feed any of your children?

a.	Yes	1
b.	No	2
c.	Refused response	9

25. How old were you when you had your first menstrual cycle?

a.	Before age 12	1
b.	Age 12 and above	2
c.	Don't know/Not sure	8
d.	Refused response	9

26. How old were you when you first started going through menopause (The change of life)?

a.	Before age 50	1
b.	Age 50 and older	2
c.	Don't know/Not sure	8
d.	Refused response	9

27. Have you had a hysterectomy (Surgical removal of the uterus/womb/sex organs)?

a. Yes 1
b. No 2
c. Don't know/Not Sure 8
d. Refused response 9

28. When you are physically sick, where do you go for medical care or treatment?

a. Private doctor 1
b. Emergency room 2
c. Clinic (**Specify**)_____
d. Refused response 9
e. Other (**Specify**)_____

29. Are there persons other than your doctor you can turn to for medical advice when you feel bad or sick?

a. Yes, (**Specify**)_____
b. No 2
c. Refused response 9

PREVENTIVE HEALTH PRACTICES

PLEASE ASK INTERVIEWEE TO GIVE THE MONTH AND YEAR FOR ANSWERS 30-35.

30. During what month and year did you last visit a doctor or other health care provider for a routine checkup?

a. _____month _____year
b. Never 0
f. Don't know/Not sure 8
g. Refused response 9

31. During what month and year did you you have the following screening tests? **(PLEASE READ EACH RESPONSE)**

a. Blood Pressure . . . . . _____month _____year [0] N [8] DK [9] Refused
b. Cholesterol . . . . . _____month _____year [0] N [8] DK [9] Refused
c. Blood Sugar . . . . . _____month _____year [0] N [8] DK [9] Refused

(FEMALES ONLY)

32. During what month and year did you last have your pap smear by a doctor or other health care provider? **IF THE INTERVIEWEE DOES NOT UNDERSTAND "PAP SMEAR", EXPLAIN AS FOLLOWS: This test is performed when the doctor or other health care provider does a pelvic exam, an exam where the female organs/cervix/tip of the womb is examined through a speculum placed in the vagina/birth canal. The pap smear is specifically a test to screen or check for cancer of the cervix/tip of the womb.)**

a. _____month _____year
b. Never 0
c. Don't know/Not sure 8
d. Refused Response 9

(MALES ONLY)

33. During what year and month did you last have your prostate examined by a doctor or other health care provider? This is an exam where the doctor or health care provider inserts a gloved finger into the rectum and feels for any hard or lumpy areas on the prostate.

a. _____month _____year
b. Never 0
c. Don't know/Not sure 8
d. Refused Response 9

34. During what month and year did you have your last fecal occult blood test by a doctor or other health care provider? This is a test where a small amount of stool (feces/bowel movement) is placed on a plastic slide or on special paper to check for hidden blood in the stool.

a. _____month _____year
b. Never 0
c. Don't know/Not sure 8
d. Refused Response 9

35. During what month and year did you last have your sigmoidoscopy by a doctor? This is an exam where a thin, flexible tube with a light is used to look inside the rectum and colon to check for abnormal areas.

a. _____month _____year
b. Never 0
c. Don't know/Not sure 8
d. Refused Response 9

INSURANCE

These next questions are about health care plans which include health insurance, prepared plans such as HMO'S (Health Maintenance Organizations), or government plans such as Medicare and Medicaid.

36. What type of insurance do you have?

a. Private 1
b. Medicaid 2
c. Medicare 3
d. None **(SKIP TO Q-39)** 8
e. Refused response 9
f. Other **(Specify)**_____

37. Does your health insurance cover all, most, some, or none of your expenses to: **(PLEASE READ EACH RESPONSE)**

a. Hospital . . . . . [1] All [2] Most [3] Some [4] None [8] DK [9] Refused
b. Doctors Visits . . . . . [1] All [2] Most [3] Some [4] None [8] DK [9] Refused
c. Preventive Health Visits . . . [1] All [2] Most [3] Some [4] None [8] DK [9] Refused
d. Other **(Specify)**_____

38. When you are not sick, does your health insurance plan cover all, most some, or none of your routine checkups or other preventive services?

a. All 1
b. Most 2
c. Some 3
d. None 4
e. Don't know/Not sure 8
f. Refused response 9

39. Was there a time during the last 12 months when you needed to see a doctor, but could not because of the cost?

a. Yes 1
b. No 2
c. Don't know/Not sure 8
d. Refused response 9

EXERCISE

Now I would like to ask you a few questions about exercising.

40. During the past month, did you participate in any physical activities or exercises such as running, aerobics, golf, gardening, or walking for exercise?

a.	Yes	1
b.	No **(Skip to Q-43)**	2
c.	Don't know/Not sure **(Skip to Q-43)**	8
d.	Refused response **(Skip to Q-43)**	9

41. How many times per week in the last month did you take part in this activity?

a.	3 or more times per week	1
b.	2 times per week	2
c.	Once per week	3
d.	Don't know/Not sure	8
e.	Refused response	9

42. And when you took part in this activity, for how many minutes or hours did you usually keep at it?

a.	Less than 20 minutes	1
b.	Between 20 & 30 minutes	2
c.	Between 31-40 minutes	3
d.	More than 40 minutes	4
e.	Don't know/Not sure	8
f.	Refused response	9

DIET

These next questions are about your diet.

43. How often do you eat the following foods? **(FOR EACH ITEM, CIRCLE NUMBER OF TIMES PER MONTH, NUMBER OF TIMES PER WEEK, OR NUMBER OF TIMES PER DAY)**

			MONTH	WEEK	DAY		
a.	Beans or Peas **(i.e., baked, pork'n beans, pinto)**	N	<1 1 2-3 5-6	<1 1 2-3 5-6	<1 1 2-3 5-6	DK	REF
b.	Vegetables **(i.e., spinach, broccoli, collards, cabbage)**	N	<1 1 2-3 5-6	<1 1 2-3 5-6	<1 1 2-3 5-6	DK	REF
c.	Potatoes **(i.e., boiled, baked, mashed)**	N	<1 1 2-3 5-6	<1 1 2-3 5-6	<1 1 2-3 5-6	DK	REF
d.	French fries or potatoe chips	N	<1 1 2-3 5-6	<1 1 2-3 5-6	<1 1 2-3 5-6	DK	REF
e.	Whole wheat bread	N	<1 1 2-3 5-6	<1 1 2-3 5-6	<1 1 2-3 5-6	DK	REF
f.	Bran Cereals **(i.e., All Bran, Raisin Bran)**	N	<1 1 2-3 5-6	<1 1 2-3 5-6	<1 1 2-3 5-6	DK	REF
g.	Margarine, oil	N	<1 1 2-3 5-6	<1 1 2-3 5-6	<1 1 2-3 5-6	DK	REF
h.	Fatback, bacon fat, butter, lard	N	<1 1 2-3 5-6	<1 1 2-3 5-6	<1 1 2-3 5-6	DK	REF
i.	Fruit **(i.e., bananas, apples, oranges)**	N	<1 1 2-3 5-6	<1 1 2-3 5-6	<1 1 2-3 5-6	DK	REF
j.	Whole milk products **(i.e., ice cream, whole milk)**	N	<1 1 2-3 5-6	<1 1 2-3 5-6	<1 1 2-3 5-6	DK	REF
k.	Meats **(i.e., chicken, fish, pork, beef)**	N	<1 1 2-3 5-6	<1 1 2-3 5-6	<1 1 2-3 5-6	DK	REF
l.	Cakes, Pies, Cookies	N	<1 1 2-3 5-6	<1 1 2-3 5-6	<1 1 2-3 5-6	DK	REF
m.	Luncheon Meats	N	<1 1 2-3 5-6	<1 1 2-3 5-6	<1 1 2-3 5-6	DK	REF
n.	Mayonnaise	N	<1 1 2-3 5-6	<1 1 2-3 5-6	<1 1 2-3 5-6	DK	REF
o.	Pastas **(i.e., spaghetti, noodles or rice)**	N	<1 1 2-3 5-6	<1 1 2-3 5-6	<1 1 2-3 5-6	DK	REF

WEIGHT CONTROL

The next few questions are about efforts to lose weight.

44. How much do you weigh? _____

45. Do you consider yourself to be:

a. Normal weight 1
b. Under weight 2
c. Overweight 3
d. Don't know/Not sure 8
e. Refused response 9

46. Are you now trying to lose weight?

a. Yes 1
b. No **(Skip to Q-48)** 2
c. Refused response **(Skip to Q-48)** 9

47. What are you doing to lose weight?

a. Eating less fatty foods . . . . . [1] Y [2] N [8] DK [9] Refused
b. Exercising daily . . . . . [1] Y [2] N [8] DK [9] Refused
c. Counting calories (or"cutting back") . . . . . [1] Y [2] N [8] DK [9] Refused
d. Other (**Specify**)_____

TOBACCO USE

Now I'd like to ask you a few questions about cigarette smoking.

48. Do you smoke cigarettes now?

a. Yes **(SKIP TO Q-50)** 1
b. No 2
c. Refused response 9

49. Have you every smoked cigarettes?

a. Yes 1
b. No **(SKIP TO Q-52)** 2
c. Refused response **(SKIP TO Q-52)** 9

50. How old were you when you first started smoking cigarettes on a regular basis?

a. Age _____
b. Don't know/Not sure 8
c. Refused response 9

51. How many cigarettes a day do/did you usually smoke?

a. Indicate number of cigarettes_____
b. Don't smoke everyday 2
c. Don't know/Not sure 8
d. Refused response 9

ALCOHOL

These next few questions are about the use of beer, wine, wine coolers, cocktails, or liquor, such as vodka, gin, rum, or whiskey, all kinds of alcoholic beverages that people drink at meals, special occasions, or when just relaxing.

52. During the past month, how many days each week did you drink any alcoholic beverages, on the average?

a. 7 Days per week (everyday) 1
b. 4-6 Days per week 2
c. 2-3 Days per week 3
d. 1 day 4
e. None **(Skip to Q-54)** 5
f. Don't know/Not sure **(Skip to Q-54)** 8
g. Refused response **(Skip to Q-54)** 9

53. How many times during the past month did you have 5 or more alcoholic drinks on any one occasion?

a. Number of times_____
b. Don't know/Not sure 8
c. Refused response 9

CANCER KNOWLEDGE, ATTITUDES, BELIEFS

The next few questions are about health issues in your community.

54. I am going to read a list of illnesses and conditions. Which one would you say is the **most** serious health problem facing your community today?

a.	Cancer **(IF YES, SKIP TO Q-56)**	1
b.	Heart disease	2
c.	Stroke	3
d.	High blood pressure	4
e.	Diabetes	5
f.	Stress	6
g.	Violence	7
h.	AIDS	8
i.	Teen Pregnancy	9
k.	Don't know/Not sure	98
l.	Refused response	99
j.	Other **(Specify)**_____	

55. Compared to **(ANSWER IN Q-54)**, how serious do you think cancer is as a health problem for your community? **(PLEASE READ EACH RESPONSE)**

a.	Just as serious	1
b.	Almost as serious	2
c.	Somewhat less serious	3
d.	Much less serious	4
e.	Don't know/Not sure	8
f.	Refused response	9

56. What do you think causes cancer? **(DO NOT READ RESPONSES AT FIRST. ALLOW THE INDIVIDUAL TO RESPOND FOR EACH ITEM. IF HE/SHE CAN NO LONGER THINK OF ANSWERS, YOU MAY THEN READ THE CHOICES. (PLEASE CIRCLE Y1 IF INDIVIDUAL RESPONDED CORRECTLY WITHOUT HELP AND Y2 IF INDIVIDUAL RESPONDED CORRECTLY ONLY AFTER THE CHOICES WERE READ).**

a.	Cigarette, pipe, or cigar smoking	[1] Y1	[2] Y2	[3] N	[8] DK	[9] Refused
b.	Snuff or chewing tobacco	[1] Y1	[2] Y2	[3] N	[8] DK	[9] Refused
c.	Drinking alcohol	[1] Y1	[2] Y2	[3] N	[8] DK	[9] Refused
d.	Diets high in fat	[1] Y1	[2] Y2	[3] N	[8] DK	[9] Refused
e.	Diets low in fruits,vegetables and fiber	[1] Y1	[2] Y2	[3] N	[8] DK	[9] Refused
f.	Other (**Specify**)_____					

57. What do you think is the most common form of cancer in women?

a.	Lung cancer	1
b.	Breast cancer	2
c.	Cervical cancer	3
d.	Don't know/Not sure	8
e.	Refused response	9
f.	Other (**Specify**)_____	

58. What do you think is the most common form of cancer in men?

a.	Prostate	1
b.	Testicular	2
c.	Lung	3
d.	Don't know/not sure	8
e.	Refused response	9
f.	Other (**Specify**)_____	

59. Which of these do you think are warning signs or symptoms of cancer. **(PLEASE READ EACH RESPONSE)**

a.	Change in bowel or bladder habits	[1] Y	[2] N	[8] DK	[9] Refused
b.	A sore that does not heal	[1] Y	[2] N	[8] DK	[9] Refused
c.	Unusual bleeding or discharge	[1] Y	[2] N	[8] DK	[9] Refused
d.	Thickening/lump in breast/elsewhere	[1] Y	[2] N	[8] DK	[9] Refused
e.	Indigestion/difficulty in swallowing	[1] Y	[2] N	[8] DK	[9] Refused
f.	Obvious change in wart/mole	[1] Y	[2] N	[8] DK	[9] Refused
g.	Nagging cough/hoarseness	[1] Y	[2] N	[8] DK	[9] Refused
h.	Other (**Specify**)_____					

(QUESTIONS 60-64, FEMALES ONLY)

60. Do you think your community needs educational workshops, to teach people about the early detection and control of breast cancer?

a. Yes 1
b. No 2
c. Don't know/Not sure 8
d. Refused Response 9

61. Would you be willing to attend workshops or meeting to learn more about breast cancer?

a. Yes 1
b. No **(SKIP TO Q-65)** 2
c. Don't know/Not sure **(SKIP TO Q-65)** 8
d. Refused response **(SKIP TO Q-65)** 9

62. Where would you like to see breast cancer workshops held?

a. Community Church 1
b. Community Recreation Center 2
c. Community School 3
d. Community Health Clinic 4
e. Don't know/Not sure 8
f. Refused response 9
g. Other **(Specify)**_____

63. Do you have a friend or relative that would attend breast cancer education programs with you?

a. Yes 1
b. No 2
c. Don't know/Not sure 8
d. Refused response 9

64. How do you most enjoy learning new information?

a. Listening to presenters 1
b. Reading 2
c. Videos 3
d. Field trips 4
e. Discussion 5
f. Don't know/Not sure 8
g. Refused response 9
h. Other **(Specify)**_____

BREAST CANCER KNOWLEDGE, ATTITUDES, BELIEFS

(FEMALES ONLY)
IF THIS IS THE PRE-TEST, SAY:

Now I would like to ask you some questions specifically about breast cancer.

IF THIS IS THE POST TEST, SAY:

I would like to first ask you some general questions about beast cancer.

65. Now I am going to read a list of factors that may or may not be associated with breast cancer. What factors do you think can possibly be associated with breast cancer? **(PLEASE READ EACH ITEM)**

a.	Age 40 years or older	[1] Y [2] N [8] DK [9] Refused
b.	Bruising or bumping the breast	[1] Y [2] N [8] DK [9] Refused
c.	Having a mother/daughter/sister who had breast cancer	[1] Y [2] N [8] DK [9] Refused
d.	Being overweight	[1] Y [2] N [8] DK [9] Refused
e.	Being around someone who has breast cancer	[1] Y [2] N [8] DK [9] Refused
f.	Having a first child after age 30	[1] Y [2] N [8] DK [9] Refused
g.	Menopause (change of life) after age 50	[1] Y [2] N [8] DK [9] Refused
h.	Onset of the menstrual cycle before age 12	[1] Y [2] N [8] DK [9] Refused
i.	Stress	[1] Y [2] N [8] DK [9] Refused
j.	High fat diet	[1] Y [2] N [8] DK [9] Refused
k.	Cigarette smoking	[1] Y [2] N [8] DK [9] Refused
l.	Other (**Specify**)_____	

66. In your opinion can breast cancer be prevented?

a.	Yes	1
b.	No	2
c.	Sometimes	3
d.	Don't know/Not sure	8
e.	Refused response	9

67. Can you name any examinations that can be done to find breast cancer in its very early stages? **(DO NOT READ RESPONSES. CIRCLE "YES" FOR EACH ITEM THAT INDIVIDUAL NAMES. IF THE INDIVIDUAL CAN NOT NAME ANY ITEMS, CIRCLE DON'T KNOW)**

a. Women examining their own breasts (BSE) . . . . . [1] Y [2] N [8] DK [9] Refused
b. Pap Smear . . . . . [1] Y [2] N [8] DK [9] Refused
c. Doctors or nurses examining the breast . . . . . [1] Y [2] N [8] DK [9] Refused
d. Chest x-ray . . . . . [1] Y [2] N [8] DK [9] Refused
e. X-ray examination/mammography of the breast . . . . . [1] Y [2] N [8] DK [9] Refused
f. Other (**Specify**)_____

68. For the following statements about breast cancer, please tell me if you agree, disagree or are undecided. **(PLEASE READ EACH RESPONSE)**

1a. It is silly for a woman to have her breasts examined when she is feeling find and is not having any problems.

a. Agree 1
b. Disagree 2
c. Undecided 8
d. Refused Response 9

2b. It is not a good idea for women to talk about breast cancer to each other.

a. Agree 1
b. Disagree 2
c. Undecided 8
d. Refused Response 9

3c. Breast cancer can be detected or found at an early stage.

a. Agree 1
b. Disagree 2
c. Undecided 8
d. Refused Response 9

4d. Finding and treating breast cancer very early in a woman can save her life.

a. Agree 1
b. Disagree 2
c. Undecided 8
d. Refused Response 9

69. What do you think your chances are of getting breast cancer? **(PLEASE READ EACH RESPONSE)**

a. Very likely 1
b. Likely 2
c. Not likely 3
d. Very unlikely 4
e. Don't know/Not sure 8
f. Refused response 9

BREAST CANCER SCREENING (FEMALES ONLY)

The next questions are about breast physical examination, which is when the breast is felt for lumps by a doctor or other health provider.

70. Have you had a breast exam by a doctor or another health care provider?

a. Yes 1
b. Yes, Other **(Specify)**_____
d. No **(SKIP TO Q-73)** 2
e. Don't know/Not sure **(SKIP TO Q-74)** 8
f. Refused response **(SKIP TO Q-74)** 9

71. During what month and year did you have your last breast exam by a doctor or another health care provider? Was it: **(PLEASE READ EACH RESPONSE)**

a. _____month _____year
b. Don't know/Not sure 8
c. Refused Response 9

72. Was your last breast exam done as part of a routine checkup, because of a breast problem, or because you've already had breast cancer?

a. Routine checkup 1
b. Breast problem 2
c. Had breast cancer 3
d. Don't know/Not sure 8
e. Refused response 9

73. What is the reason you did not have a breast exam by a doctor or another health care provider?_____

_____

74. How often do you think a woman your age should have a breast exam by a doctor or another health care provider?

a. Monthly 1
b. Yearly 2
c. Whenever the doctor says so 3
d. Never 5
e. Don't know/Not sure 8
f. Refused Response 9
g. Other (**Specify**)_____

75. How often do you perform breast self-exams? **(examining your breasts for lumps)**

a. More than once per month 1
b. Once per month 2
c. Less than once per month 3
d. Never **(SKIP TO Q-77)** 4
e. Refused response **(SKIP TO Q-78)** 9

76. How did you learn to do breast self-examination? **(PLEASE READ EACH RESPONSE)**

a. physician . . . . . [1] Y [2] N [8] DK [9] Refused
b. nurse . . . . . [1] Y [2] N [8] DK [9] Refused
c. mother, sister or other relative . . . . . [1] Y [2] N [8] DK [9] Refused
d. friend . . . . . [1] Y [2] N [8] DK [9] Refused
e. self-taught(besides pamphlet/magazine) . . . . . [1] Y [2] N [8] DK [9] Refused
f. learned from a pamphlet or magazine . . . . . [1] Y [2] N [8] DK [9] Refused
g. TV . . . . . [1] Y [2] N [8] DK [9] Refused
h. workshop . . . . . [1] Y [2] N [8] DK [9] Refused
i. Other (**Specify**)_____

77. What is the main reason that you do not perform breast self-exams on a regular basis?

a. I forget 1
b. I do not trust my ability 2
c. I do not know how 3
d. I do not believe it increases my chance of survival 4
e. I am afraid 5
f. Don't know/Not sure 8
g. Refused response 9
h. Other (**Specify**)_____

78. How often do you think a woman your age should perform breast self-exams?

a. Monthly 1
b. Yearly 2
c. Whenever the doctor says so 3
d. Never 5
e. Don't know/Not sure 8
f. Refused Response 9
g. Other amount of time **(Specify)**_____

79. Have you ever heard of a mammogram?

a. Yes 1
b. No 2
c. Don't know/Not sure 8
d. Refused response 9

80. Have you ever had a mammogram (A mammogram is an x-ray of the breast to look for abnormalities or to screen for cancer)?

a. Yes 1
b. No **(SKIP TO Q-84)** 2
c. Don't know/Not sure **(SKIP TO Q-85)** 8
d. Refused response **(SKIP TO Q-85)** 9

81. During what month and year did you have your last mammogram?

a. _____month _____year
b. Never**(SKIP TO Q-84)** 5
c. Don't know/Not sure**(SKIP TO Q-82)** 8
d. Refused response **(SKIP TO Q-85)** 9

82. Was your last mammogram done as part of a routine checkup, because of a breast problem, or because you've already had breast cancer?

a. Routine checkup 1
b. Breast problem 2
c. Had breast cancer 3
d. Don't know/Not sure 8
e. Refused response 9

83. Who encouraged you to get your last mammogram?

a. Respondent's idea 1
b. Health Care Providers 2
c. Media (T.V., Radio, Newspaper etc.) 3
d. Relative 4
e. Friend 5
f. Don't know/Not sure 8
g. Refused response 9
h. Other (**specify**)_____

84. What is the reason you did not have a mammogram?

_____

_____

_____

85. How often do you think a woman your age should have a mammogram?

a. Monthly 1
b. Yearly 2
c. Whenever the doctor says so 3
d. Never 5
e. Don't know/Not sure 8
f. Refused Response 9
g. Other (**Specify**)_____

This completes the interview. We appreciate your time and cooperation very much.

RECORD THE FOLLOWING INFORMATION AFTER THE INTERVIEW.

1. Generally, was the respondent :

   a. Very cooperative 1
   b. Somewhat cooperative 2
   c. Somewhat uncooperative 3
   d. Very uncooperative 4

2. When you first begin the interview, was the respondent:

   a. Suspicious or reluctant 1
   b. Reserved, but friendly 2
   c. Welcomed you 3
   d Other 4

3. Which other persons, 11 years of age or older, were present during the interview?

   Relationship _____

   Relationship _____

   Relationship _____

DATE COMPLETED: _____
M/D/Y

TIME INTERVIEW COMPLETED: _____ A.M_____ P.M.

PHYSICIAN SURVEY

PHYSICIAN QUESTIONNAIRE

_____

A. DEMOGRAPHIC PROFILE

For each question, please circle the appropriate responses as indicated.

1. Gender: ☐ Male ☐ Female

2. Race:

   a. White (non-hispanic)

   b. Hispanic (non-white)

   c. Black

   d. Native American

   e. Asian/Pacific Islander

   f. Other **(please specify)**_____

3. Professional Medical Practice: **(Please circle one response)**

   a. Family Practice

   b. Internal Medicine

   c. Ob-Gyn

   d. Preventive Medicine/Public Health

   e. Surgery

   f. Pediatrics

   g. Other **(please specify)**_____

4. How long have you been in practice? _____
years

B. BREAST CANCER EDUCATION AND TRAINING

1. Have you attended any educational programs on cancer education and screening in the last 2 years?

   a. Yes

   b. No **(If No, skip to question 4)**

2. During these education programs which of the following areas did you learn most about? **(Please circle all responses that apply)**

   a. Breast cancer screening

   b. Assessing breast cancer risk

   c. Cervical cancer screening

   d. Assessing cervical cancer risk

   e. Assessing cancer risk generally

   f. Techniques for educating patients about cancer risk and screeningg.

   g. Other cancer screening**(please specify)**_____

3. Would you say this previous education helped you in talking with your patients about cancer prevention and screening:

   a. Very much

   b. Somewhat

   c. Not at all

4. Which of the following methods of education would be most useful to you for continuing education programs about cancer? **(Please circle all responses that apply)**:

   a. Teleconferencing

   b. Written materials

   c. One-on-one teaching

   d. Workshops

   e. Video self-instruction

   f. Annual conventions/conferences

   g. Role play

   h. Other **(please specify)**_____

C. BREAST CANCER RISK

1. At approximately what age do you think women are <u>most likely</u> to get breast cancer?

   a. Less than 40 years of age

   b. Between 40 and 50 years of age

   c. There is no difference in onset for women of different ages

   d. Over 50 years of age

   e. Don't Know

2. Which of the following do think would increase a women's chances of getting breast cancer? **(Please circle all responses that apply)**:

   a. Increasing age

   b. Overweight

   c. Taking birth control pills

   d. Smoking

   e. A family history of breast cancer

   f. Stressful lifestyle

   g. Other **(please specify)**_____

3. How important do you think the following are in keeping women from getting clinical breast examinations and mammograms: **(For each item, please circle one response: VI - very important, SI - Somewhat Important, NVI- Not Very Important)**

a. Fear that an exam will find cancer . . . . . [1] VI [2] SI [3] NVI

b. They don't go to the doctor unless they have a problem . . [1] VI [2] SI [3] NVI

c. Cultural beliefs . . . . . [1] VI [2] SI [3] NVI

d. Language barriers . . . . . [1] VI [2] SI [3] NVI

e. Women don't know they are at risk for breast cancer . . . [1] VI [2] SI [3] NVI

f. The cost of an examination . . . . . [1] VI [2] SI [3] NVI

g. Their doctors don't tell them to have one . . . . . [1] VI [2] SI [3] NVI

h. They are embarrassed to have a breast exam . . . . . [1] VI [2] SI [3] NVI

i. They don't think they need one . . . . . [1] VI [2] SI [3] NVI

j. Transportation problems . . . . . [1] VI [2] SI [3] NVI

k. Discomfort associated with mammogram . . . . . [1] VI [2] SI [3] NVI

l. Lack of insurance . . . . . [1] VI [2] SI [3] NVI

m. Lack of time for patient to get exam . . . . . [1] VI [2] SI [3] NVI

n. Other **(please specify)**_____

D. PATIENT EDUCATION & COUNSELING ABOUT BREAST CANCER PREVENTION

1. What percentage of the women in your practice are: **(For each item, please circle one response)**

a. Less than 35 years of age . . . . [1] None [2] < 10% [3] 10-25% [4] 26-50% [5] > 50%

b. Between 35 and 40 years . . . . [1] None [2] < 10% [3] 10-25% [4] 26-50% [5] > 50%

c. Between 41 and 64 years . . . . [1] None [2] < 10% [3] 10-25% [4] 26-50% [5] > 50%

d. Over 65 years . . . . . [1] None [2] < 10% [3] 10-25% [4] 26-50% [5] > 50%

e. African American . . . . . [1] None [2] < 10% [3] 10-25% [4] 26-50% [5] > 50%

f. Native American . . . . . [1] None [2] < 10% [3] 10-25% [4] 26-50% [5] > 50%

g. Hispanic . . . . . [1] None [2] < 10% [3] 10-25% [4] 26-50% [5] > 50%

h. Other **(please specify)**_____

2. Do you see talking with patients about breast cancer prevention as:

   a. A large part of your practice

   b. A small part of your practice

   c. Not part of your practice at all

3. With regard to talking with your patients about breast health, would you say you are:

   a. Very interested

   b. A little interested

   c. Not interested

4. On average how much time do you spend each week educating your patients about breast health?

   a. None

   b. 1-3 hours

   c. 4-6 hours

   d. 7-9 hours

   e. 10 or more

5. About what percentage of the women in your practice who are 40 and above do you refer each year for screening mammography?

   a. None

   b. Less than 10 percent

   c. Between 10 and 25 percent

   d. Between 26 and 50 percent

   e. Greater than 50 percent

   f. Not Applicable

6. What breast cancer screening tests and procedures do you **usually** recommend for your patients: **(Please circle all responses that apply)**

   a. Breast self-examination

   b. An annual doctors examination of the breast **(palpation)**

   c. Mammography

   d. All of the above

   e. None of the above

7. The following statements are about your feelings concerning breast cancer prevention. **For each item below, please circle one response: (SA - Strongly Agree, A - Agree, DA - Disagree, SD - Strongly Disagree)**

a. I have sufficient knowledge to counsel patients . . . . . [1] SA [2] A [3] DA [4] SD

b. I do not have enough time to educate patients . . . . . [1] SA [2] A [3] DA [4] SD

c. When I counsel a patient, I am concerned that I may give incorrect information . . . . . [1] SA [2] A [3] DA [4] SD

d. After I counsel a patient, I don't think they comply with my recommendations . . . . . [1] SA [2] A [3] DA [4] SD

e. There should be more education about breast cancer done in the community . . . . . [1] SA [2] A [3] DA [4] SD

f. I don't think the women who need breast cancer education and screening are the ones I see regularly in my office . . . . . [1] SA [2] A [3] DA [4] SD

g. It's sometimes difficult to know what to tell my patients . [1] SA [2] A [3] DA [4] SD

h. Patients don't usually practice early cancer detection measures such as self breast examination . . . . . [1] SA [2] A [3] DA [4] SD

i. There are limited follow-up resources in the community for referral of patients for breast examinations **(such as mammography)** . . . . . [1] SA [2] A [3] DA [4] SD

E. In which of the following areas would you like to have more education?

a. Teaching breast self exams to patients

b. Performing clinical breast exams

c. Counseling patients in breast cancer prevention

d. Other **(specify)**_____

F. OTHER COMMENTS OR CONCERNS:

ORIENTATION PACKET FOR TENANT ASSOCIATION PRESIDENT

BREAST HEALTH EDUCATION STUDY PROGRAM

F A C T S H E E T

1) **Who Can Participate In The Study**

Women between the ages of 18 and 74. Men and women can participate in the community assessment survey that will be conducted prior to the study.

2) **What Is The Breast Health Education Study**

A project that will study the effectiveness of promoting breast health in minority women by educating and motivating them to get mammograms and perform breast self-exams on a regular basis. It will also look at the effectiveness of a program that promotes breast health by educating and motivating physicians and other health professionals to discuss and promote clinical breast exams, mammographies and breast self-examinations to their female patients.

3) **When**

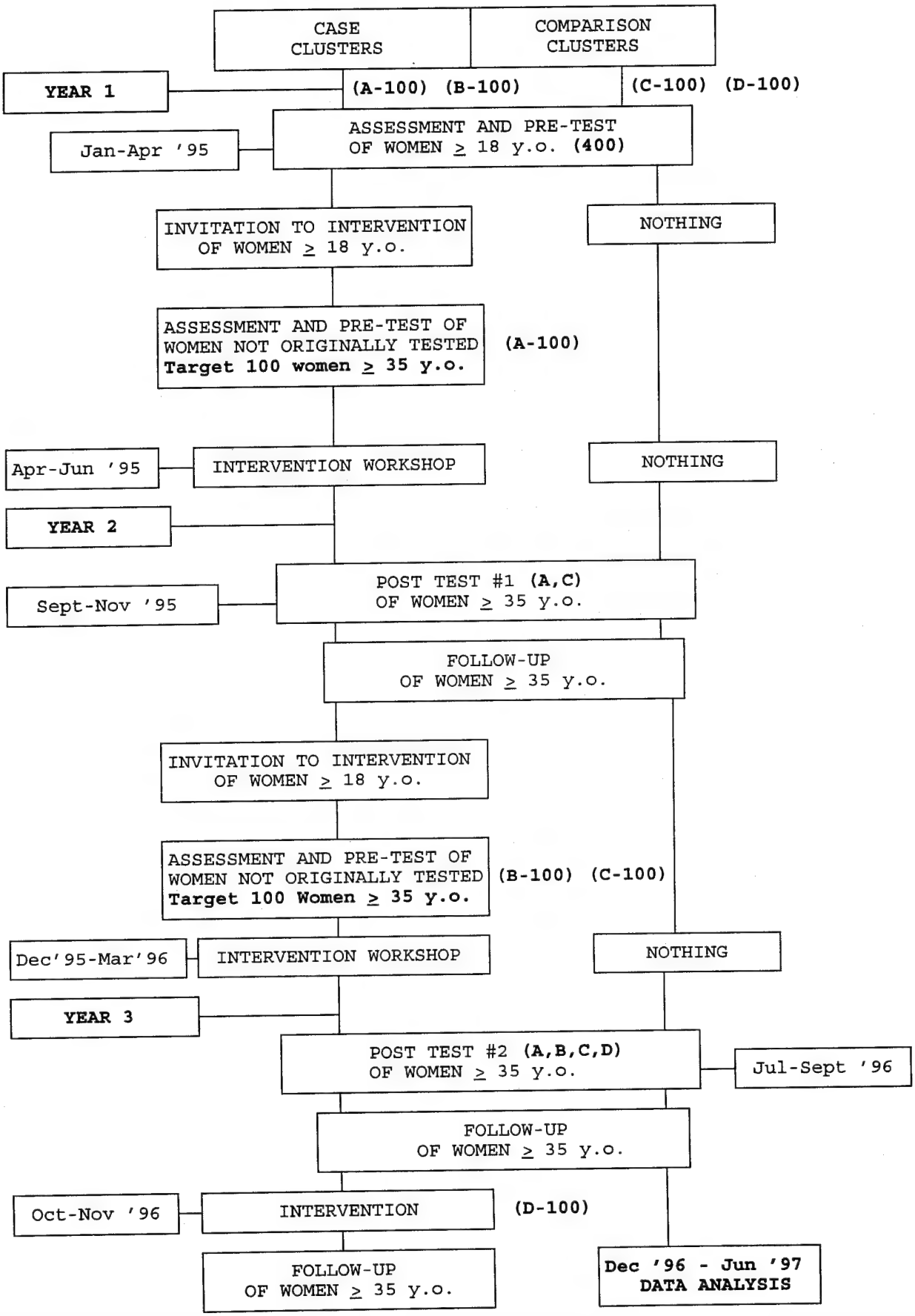
The project began in July of 1994 and will end in June of 1997.

4) **Where**

The Atlanta Housing Authority communities chosen for this project are:

- Antoine Graves
- Carver Homes
- Cosby Spears A&B
- John O. Chiles
- Graves Annex
- M. L. King
- East Lake Meadows

BREAST HEALTH EDUCATION STUDY



BREAST HEALTH EDUCATION STUDY

CLUSTER I HIGH RISE UNITS Women ≥ 62 y.o.	CLUSTER II LOW RISE UNITS Women < 62 y.o
GROUP A (CASES) **Antone Graves** 210 Units 210 Individuals **Graves Annex** 100 Units 101 Individuals **Martin Luther King** 154 Units 142 Individuals	GROUP B (CASES) **East Lake Meadows** 650 Units 2,157 Individuals
GROUP C (COMPARISON) **Cosby Spears I/Cosby Spears II** 282 Units 291 Individuals **John O. Childs** 250 Units 255 Individuals	GROUP D (COMPARISON) **Carver Homes** 990 Units 2,612 Individuals

ATTENTION ALL MEN AND WOMEN

HERE IS A GREAT OPPORTUNITY FOR HOUSING COMMUNITY RESIDENTS

APPLICATION PERIOD: JULY 3-12, 1995

TITLE: COMMUNITY HEALTH VOLUNTEER

All Community Health Volunteers will receive special training for the Morehouse School of Medicine Breast Health Education Study to be conducted in the following communities:

- Antoine Graves
- M. L. King
- John O. Chiles
- Graves Annex
- Cosby Spears A&B
- Carver Homes
- East Lake Meadows

RESPONSIBILITY:

The Community Health Volunteer is responsible for conducting and completing interviews with residents of at least two (2) Atlanta housing communities.

DUTIES:

1. Attend assigned training workshops and special events.
2. Conduct door-to-door interviews with residents for the Morehouse School of Medicine Breast Health Education Study, using an assessment/questionnaire to survey community.
3. Assist in the coordination of workshops.
4. Provide follow-up visits to participants if applicable.

QUALIFICATIONS:

1. A housing community resident in good standing
2. Must be able to read, write and spell well
3. Willing to work in a designated housing community other than their own
4. Willing to be trained
5. Must be able to communicate well with others
6. High school diploma or GED preferred

INTERESTED PERSONS SHOULD PICK UP APPLICATIONS AT THE MANAGEMENT OFFICE OR RESIDENT ASSOCIATION PRESIDENT

Morehouse School of Medicine
Application for Community Health Volunteers
for the Breast Health Education Study

PLEASE PRINT ALL INFORMATION

Name:_____ What is your birthdate? _____
month/day/year

Address: _____
(street address and apt. no.)

_____
(city) **(state)** **(zip code)**

How long have you lived at the above address? _____
(yrs./months)

How long do you plan to remain at the above address? _____
(yrs./months)

Telephone No. or number(s) where you can be reached: _____

_____

What was the highest grade of school you completed?

[ ] High School Diploma
[ ] Trade or Vocational School
[ ] College, at least one year
[ ] College Degree (specify):_____
[ ] Other: _____

What type of work have you done in the past?

[ ] Secretarial
[ ] Teaching
[ ] Recreational
[ ] Domestic Worker (maid)
[ ] Child Care
[ ] Construction
[ ] Security
[ ] Janitorial
[ ] Community Outreach
[ ] Other: _____

OVER

Can you work flexible hours? ☐ Yes ☐ No **If Yes, When?** ☐ **A.M.** ☐ **P.M.**

Have you done any volunteer work in the community? ☐ Yes ☐ No

If yes, Where? _____

_____

Tell us the reason(s) why you are interested in being a community health volunteer:

_____

_____

_____

Signature: _____ Date: _____

HOUSING AUTHORITY/BHES & OTHER CORRESPONDENCE

Memorandum

Date: May 30, 1995

To: Dr. Beverly Taylor, Morehouse School of Medicine

From: Maggie L. Glover, Fulton County Department of Family and Children Services

Re: Income Consideration For Community Health Workers

Per our discussion, I have reviewed our policy on Income and have determine that there is one possible source we can place the pending payments under that would allow the income to be excluded.

Disregarded Income:

Income form the following source will be disregarded and shall not be considered in determining need or the amount of the assistance....

> Payments to volunteers under Title I, Section 404 (g) of P.L. 92-113; and payments for provision of volunteer services or reimbursement of out of pocket expense made to individual volunteers.
>
> Reimbursements for out-of-pocket expenditures made to any volunteer, employee, or other individual. Payments for supportive services made to individual volunteers serving as foster grandparents, senior health aids, or senior companions; and to persons serving in SCORE and ACE and any other programs under Title II and III.

This is information that should give you some idea as to how to compensate the individuals hired as Health Workers. I will say at this point that, I have no idea as to the actual verbiage in the Titles stated. This may be something you or someone with the program can research. If I can assist you further, please contact me.

Chicago State University
BOARD OF GOVERNORS UNIVERSITIES

9501 S. King Drive
Chicago, Illinois 60628-1598

College of Nursing & Allied Health Professions
Business and Health Sciences 607 ~ 610
312 / 995-2552 ~ 3987 • FAX 312 / 995-4484

May 17, 1995

Beverly Taylor
Morehouse College
School of Medicine
Atlanta, GA 30314

Dear Dr. Taylor:

I read about your research project ***Breast Health Education*** in the 1993-94 award list from the *United States Medical Research and Material Command.* I would appreciate any information you could send me about your project.

Thank you in advance for your attention to this request.

Sincerely,

Lucille Davis

Lucille Davis, PhD, RN
Dean
College of Nursing and Allied Health Professions

ms

Executive Committee Chairman
Louis W. Sullivan, M.D.
Vice Chairman
Andrea D. Fox
Regional Director
Joyce Q. Sheats

Southeastern Region

NATIONAL BLACK LEADERSHIP INITIATIVE ON CANCER

MEMORANDUM

TO: Karen Williams

FROM: Joyce Sheats, RN, MPH
Regional Director

SUBJECT: Morehouse School of Medicine Breast Health Education Study Meeting

DATE: May 11, 1995

^^

Per our conversation on Monday, enclosed is the information on the Morehouse School of Medicine Breast Health Education Study and the National Black Leadership Initiative on Cancer.

I spoke with Ms. Davis on Wednesday morning regarding our getting together at her office on Tuesday the 16th at 12:00 or 1:00 p.m. She said that she would let you know of her availability. By the time you receive this memo, I'm sure that we will have talked again.

I look forward to working with you and if you have any questions, please do not hesitate to call me.

Enclosures

cc: Beverly D. Taylor, M.D.
Marseilles Grissom
Eva Davis

bjt

720 Westview Drive, S.W.
Atlanta, GA 30310
404/752-1949
FAX 404/756-8674

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Southeastern Region

NATIONAL BLACK LEADERSHIP INITIATIVE ON CANCER

April 13, 1995

Joanne Keith
President
Grady Homes/Antonne Graves/Graves Annex
170 Hilliard St.
Apt. #408
Atlanta, GA 30312

Dear Ms. Keith:

This letter is to confirm your attendance at a meeting which has been scheduled by Ms. Grissom on Tuesday, April 18, 1995 from 11:00 a.m. - 12:00 noon at the Cecil B. Day Building, 46 5th St.

The purpose of this meeting is to introduce a new and exciting program called the Morehouse School of Medicine Breast Health Education Study. We will need the assistance and participation of at least six Atlanta Housing Authority communities and their residents to successfully carryout the goals and objectives of the project.

You will have an opportunity to ask questions and meet some of the project staff from the Morehouse School of Medicine. We have had several planning meetings with the Atlanta Housing Authority and we are very pleased with the partnership that has developed.

Thank you in advance for your willingness to assist us with the implementation of the Breast Health Education Study and we look forward to working with you.

If you have any questions, please do not hesitate to call me at (404) 752-1949 or Ms. Grissom at (404) 815-4028.

Sincerely,

Joyce Sheats

Joyce Sheats, RN, MPH
Regional Director

bjt

cc: Beverly D. Taylor, MD
Marseilles Grissom

720 Westview Drive, S.W.
Atlanta, GA 30310
404/752-1949
FAX 404/756-8674

Housing Authority of the City of Atlanta

"Helping People Help Themselves"

(404) 892-4700
FAX (404) 249-1326

November 23, 1993

Beverly D. Taylor, MD
Assistant Professor
Community Health/Preventive Medicine
Morehouse School of Medicine
720 Westview Drive, SW
Atlanta, GA 30310

Dear Dr. Taylor:

The Atlanta Housing Authority (AHA) writes this letter of support for your application to the Medical Research and Development Command of the United States Army to receive funding for a Breast Health Education Study. Based on the information received from your office regarding this project, we enthusiastically support your aim to validate the efficacy of community-based educational initiatives in promoting breast health in low income, minority women. And throughout these initiatives, women will be motivated to seek mammograms and perform breast self-examinations on a regular basis.

We are also please to know that two of the targeted communities will be selected from Atlanta Housing Authority developments. In as much as we have developed good working relationships with the Morehouse School of Medicine, you will continue to receive our full cooperation in the planning and implementation of this project.

We look forward to hearing from you and wish you much success.

Sincerely,

Rod Solomon
Deputy Executive Director/
Acting Director of Resident Initiatives

RS:BR

739 W. Peachtree St., NE Atlanta, GA 30365

Executive Committee Chairman
Louis W. Sullivan, M.D.
Vice Chairman
Andrea D. Fox
Regional Director
Joyce Q. Sheats

Southeastern Region

NATIONAL BLACK LEADERSHIP INITIATIVE ON CANCER

January 10, 1994

Thelma Beck
304 Flynn Rd.
Apartment #95
Atlanta, GA 30354

Dear Ms. Beck:

Per your request, enclosed is a copy of the abstract for the Breast Health Education Study that is being proposed by the Morehouse School of Medicine. If the study is funded, we look forward to working with you and the Gilbert Gardens residents who will participate in this project.

Also, for your information, I have enclosed a copy of the National Black Leadership Initiative on Cancer (NBLIC) Fact sheet and a recent NBLIC newsletter.

Please let me know if I can be of any assistance to you while awaiting approval of the application.

Sincerely,

Joyce Sheats

Joyce Sheats, RN, MPH
Regional Director

Enclosures

bjt

720 Westview Drive, S.W.
Atlanta, GA 30310
404/752-1949
FAX 404/752-5007

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Vice Chairman
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Southeastern Region

NATIONAL BLACK LEADERSHIP INITIATIVE ON CANCER

January 10, 1994

Laura Walker
2405 Leila Lane
Apartment #169
Atlanta, GA 30315

Dear Ms. Walker:

Per your request, enclosed is a copy of the abstract for the Breast Health Education Study that is being proposed by the Morehouse School of Medicine. If the study is funded, we look forward to working with you and the Leila Valley residents who will participate in this project.

Also, for your information, I have enclosed a copy of the National Black Leadership Initiative on Cancer (NBLIC) Fact sheet and a recent NBLIC newsletter.

Please let me know if I can be of any assistance to you while awaiting approval of the application.

Sincerely,

Joyce Sheats

Joyce Sheats, RN, MPH
Regional Director

Enclosures

bjt

720 Westview Drive, S.W.
Atlanta, GA 30310
404/752-1949
FAX 404/752-5007

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Southeastern Region

NATIONAL BLACK LEADERSHIP INITIATIVE ON CANCER

January 10, 1994

Verna Mobley
651 Greensferry Ave.
Apartment #437
Atlanta, GA 30314

Dear Ms. Mobley:

Per your request, enclosed is a copy of the abstract for the Breast Health Education Study that is being proposed by the Morehouse School of Medicine. If the study is funded, we look forward to working with you and the University/John Hope Homes residents who will participate in this project.

Also, for your information, I have enclosed a copy of the National Black Leadership Initiative on Cancer (NBLIC) Fact sheet and a recent NBLIC newsletter.

Please let me know if I can be of any assistance to you while awaiting approval of the application.

Sincerely,

Joyce Sheats

Joyce Sheats, RN, MPH
Regional Director

Enclosures

bjt

720 Westview Drive, S.W.
Atlanta, GA 30310
404/752-1949
FAX 404/752-5007

Morehouse School of Medicine
Breast Health Education Project
and
Educational Playmakers, Inc.
Presents

Nightmare

by

Charlee Lambert

Time Five o'clock in the afternoon

Place The office of Dr. Jim Andrews

Actors (In order of appearance)

Dr. Jim Andrew	John Burton
Mary Ingle	Carol Clarke
Maria Jackson	Veronica Byrd
Marla Williams	Faye McQueen
Nurse	Faye McQueen
Bill Jackson	John Burton

Dr. Andrews falls asleep and dreams of his last three patients of the day. What a nightmare! All three women have breast cancer and may be dying. What reasons caused these women not to follow guidelines for good breast health? Do the authorieies agree on these guidelines? How is a doctor to know which ones to follow? Older women and minorities are more apt to die from breast cancer? What are the reasons? What can you do to encourage women to self examine and get mammograms? As a health care provider what is your responsibility?

For information on this program:

Educational Playmakers, Inc.
809 Castle Falls Drive NE
Atlanta, GA 30329
Tel. 404/982-0790
Fax 404/633-5023

Project funded by: United States Army, Department of Defense.

Georgia State Medical Association

July 5, 1995

Dear Members and Friends:

Thank you very much for your participation in Georgia State Medical Association's (GSMA) 102nd Annual Convention. Our continuing medical education program was approved for 23 hours of Category 1 for Physician's Achievement Award of the National Medical Association and the Physician's Recognition Award of the American Medical Association, and 16.75 hours by the American Academy of Family Physicians. Thanks to you, our attendance was at an all time high -- up 30% from 1994!

Please mark your calendars for GSMA's 103rd convention. It will again take place at the Hilton Resort, Hilton Head Island, South Carolina -- **June 19-22, 1996**. Please make your reservations early!

Our Quarterly Magazine is an excellent vehicle for sharing your ideas and opinions with our membership. The Summer 1995 edition is currently in production and will be mailed early next month. However, you still have until July 14 to include any news/information you would like to share. (If you would like to place an ad in this issue, please call us for rates and space availability.)

I look forward to seeing you at other activities throughout the year, but definitely at Hilton Head Island next year.

Again, on behalf of our President, Dr. Patrick Griffith; Chairman of the Board, Dr. Philip G. Wiltz, Jr.; 1995 Program Chair, Dr. Gary C. Richter, and Program Co-chairs, Dr. Lawrence Sanders, Dr. Sheila Robinson, and Dr. Ruth Neal, thank you for your contributions to the continuing success and growth of Georgia State Medical Association.

Sincerely,

Kathryn Daniels

M. Kathryn Daniels
Executive Director

720 Westview Drive, S.W. • Atlanta, Georgia 30310-1495 • (404) 752-1564

FOCUS GROUP INFORMATION

ANNOUNCEMENT

YOU ARE INVITED TO ATTEND A FOCUS GROUP SESSION

FOR THE

MOREHOUSE SCHOOL OF MEDICINE BREAST HEALTH EDUCATION STUDY

We need 10 women between the ages of 18-72 to participate.

WHEN: ***WEDNESDAY, FEBRUARY 15, 1995***

WHERE: ***LEILA VALLEY COMMUNITY CENTER***

TIME: ***7:00 P.M. - 8:00 P.M.***

Light refreshments will be served and each participant will receive a free ***Down Home Healthy Cookbook*** *with recipes of two African American Chefs.*

For More Information Contact Patricia Tucker at (404) 627-3271.

Sponsored by: ***Morehouse School of Medicine and the Atlanta Housing Authority***

Executive Committee Chairman
Louis W. Sullivan, M.D.
Vice Chairman
Andrea D. Fox
Regional Director
Joyce Q. Sheats

Southeastern Region

NATIONAL BLACK LEADERSHIP INITIATIVE ON CANCER

December 16, 1994

Thelma L. Beck
400 Flynn Rd., SE
Apt. #95
Atlanta, GA 30351

Dear Ms. Beck:

As mentioned in our conversation last week, the Morehouse School of Medicine Breast Health Education Study is in its first phase of implementation. We have had several planning meetings with the Atlanta Housing Authority and we are very pleased with the partnership that has developed.

We are presently scheduling focus group sessions with Gilbert Gardens and Leila Valley housing communities in an effort to obtain information from female residents about their cultural attitudes and practices and their breast cancer knowledge, attitudes and practices. The first session will be conducted on Thursday, December 29th at Gilbert Gardens following the tenant association meeting at 6:30 p.m.. We would like to have 10 to 12 women of various ages (18–75) participate in the focus group, which will last about 45 minutes. Light refreshments will be served. Additionally, each participant will receive a cookbook with recipes by two famous African American chefs.

We are very appreciative of your efforts to assist us with the implementation of the Breast Health Education Study and we look forward to working with you and other Atlanta Housing Authority communities.

If you have any questions, please do not hesitate to call me at (404) 752–1949.

Happy Holidays!

Sincerely,

Joyce Sheats, RN, MPH
Regional Director

bjt

cc: Beverly D. Taylor, M.D.
Marseilles Grissom
Fred Murphy

720 Westview Drive, S.W.
Atlanta, GA 30310
404/752-1949
FAX 404/756-8674

Breast Cancer Education Study

Focus Group Discussion Categories

Cultural Attitudes and Practices

1. What do people in low-income African American communties consider to be "good health/poor health".

2. How important is good health? Why?

3. How do you feel about your health care provider(s)?

4. What changes in "quality of life" do individuals or groups in low-income African American communities desire?

5. What do individuals in low-income African American communities think are the leading causes of death and disability?

6. What are common beliefs in low-income African American communities concerning disease prevention?

7. Are there culturally specific methods/strategies (Home Remedies) used by African Americans in low-income communities to maintain good health?

8. Are there culturally specific methods/strategies which could be used to present health information to individuals in low-income African American communities?

Breast Cancer Knowledge, Attitudes and Practices

1. What are the most common forms of cancer among African American women?

2. What do you think are the major causes of breast cancer among African American women?

3. Is it important to know how to conduct breast self-examinations?

4. What is a mammogram?

5. Would you like to see health programs presented in your community on the subject of breast cancer screening and prevention? Why?